

Rancho Buena Vista High School

SECTION 1: INFORMATION ABOUT PATIENT (PLEASE PRINT)			
LAST NAME		FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH: MONTH	DAY	YEAR	MOBILE PHONE NUMBER (PATIENT OR GUARDIAN)
ADDRESS			APT/ROOM #:
CITY		STATE	ZIP
NAME OF LEGAL GUARDIAN: LAST NAME		FIRST NAME	MIDDLE INITIAL
SEX (GENDER ASSIGNED AT BIRTH)	RACE		ETHNICITY
FEMALE	AMERICAN INDIAN OR ALASKA NATIVE	WHITE	HISPANIC OR LATINO
MALE	ASIAN	OTHER ASIAN	NOT HISPANIC OR LATINO
	BLACK OR AFRICAN AMERICAN	OTHER NONWHITE	UNKNOWN
	NATIVE HAWAIIAN OR OTHER	OTHER PACIFIC ISLANDER	
	PACIFIC ISLANDER	UNKNOWN	
PRIMARY INSURANCE CARRIER ID #:		GRP #:	
INSURANCE COMPANY:		INSURANCE COMPANY PHONE #:	
INSURED'S NAME:	RELATIONSHIP:	INSURED'S DATE OF BIRTH:	
SECONDARY INSURANCE CARRIER ID #:		GRP #:	
INSURANCE COMPANY:		INSURANCE COMPANY PHONE #:	
INSURED'S NAME:	RELATIONSHIP:	INSURED'S DATE OF BIRTH:	
IS THIS THE PATIENT'S FIRST OR SECOND DOSE OF THE COVID-19 VACCINATION?	FIRST DOSE	SECOND DOSE	

SECTION 2: COVID-19 SCREENING QUESTIONS		
SECTION 2 WILL BE COMPLETED WITH PATIENT JUST PRIOR TO VACCINE ADMINISTRATION		
PLEASE CHECK YES OR NO FOR EACH QUESTION		
Do you have today or have you had at any time in the last 10 days a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?	YES	NO
Have you tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days?	YES	NO
Have you had a severe allergic reaction (e.g. needed epinephrine or hospital care) to a previous dose of this vaccine or to any of the ingredients of this vaccine?	YES	NO
Have you had any other vaccinations in the last 14 days (e.g. influenza vaccine, etc.)?	YES	NO
Have you had any COVID-19 Antibody therapy within the last 90 days (e.g. Regeneron, Bamlanivimab, COVID Convalescent Plasma, etc.)	YES	NO
SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE		
PLEASE CHECK YES OR NO FOR EACH QUESTION		
Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies or reactions to any medications, foods, vaccines or latex?	YES	NO
For women, are you pregnant or is there a chance you could become pregnant?	YES	NO
For women, are you currently breastfeeding?	YES	NO
Are you immunocompromised or on a medication that affects your immune system?	YES	NO
Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?	YES	NO
Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's vaccine did you receive:	YES	NO

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- I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 12 years of age; or (c) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to Inspire Diagnostics or its agents to administer the COVID-19 vaccine.
- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals either 12 years of age or older or 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Inspire Diagnostics and its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
- I acknowledge that: (a) I understand the purposes/benefits of the state's immunization registry and (b) Inspire Diagnostics will include my personal immunization information in the appropriate state registry and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize Inspire Diagnostics or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to Inspire Diagnostics or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if Inspire Diagnostics invoices me after the time of service, upon receipt of such invoice.

Signature of Patient or Authorized Representative: _____ Date: _____

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

For Administrative Use Only

Site	Manufacturer	Lot # Unit of Use	Expiration Date

Vaccinator Print Name: _____

Signature: _____

Date: _____

Please submit or e-mail this form to alejandraaraiza@vistausd.org