COVID-19 IMMUNIZATION CONSENT FORM # _____

Date	Clinic Site	Patient Chart/ WebIZ No.	Vaccinator/Title	VACCINATION Start Time: ___ : ___ AM / PM	Post Observation Time: ____ : ____ AM / PM
				Verified by (DPHSS Staff Name): _____	

Vaccine	Dose # 1	Dose # 2	Route	Dosage	Site: RA, LA RT, LT	Lot #	Mfr.	VIS Date
			IM	0.3 mL			PFZ	
			IM	0.5 mL			MOD	

Patient Information

Patient: Last Name First Name Middle	Social Security No.	DOB:	Age:	Sex: ◉ Male ○ Female

Mailing Address:	Home Phone Number:	Ethnicity:	Insurance:	Tier:
		○ Chamorro ○ Filipino ○ Yapese ○ Chinese ○ Pohnpeian ○ Korean ○ Chuukese ○ Vietnamese ○ Kosraen ○ Japanese ○ Palauan ○ Caucasian ○ Marshallese ○ African-American ○ Other (specify): _____	◉ Medicaid ○ MIP ○ Calvo's ○ BC/BS ○ FHP/Takecare ○ Staywell ○ Aetna ○ Military ○ NetCare ○ Nanbo's ○ Medicare ○ No Insurance ○ Multicover ○ Other (specify): _____	○ Healthcare Workers ○ Essential Workers ○ General Population ○ Other (specify): _____
Residing Village:	Other Contact Number:			
E-mail Address:		Occupation & Employer:		

Guam Immunization Registry

Guam law states that all vaccines administered on Guam must be submitted to DPHSS for inclusion in the Guam Immunization Registry (GuWebIZ). For individuals who choose not to have vaccinations recorded in GuWebIZ, contact your immunization provider for additional information.

PATIENT HEALTH QUESTIONNAIRE

	The following questions will help us determine which vaccines will be given today. If a question is not clear, please ask the nurse or doctor to explain it. Please check the appropriate box. If the answer is "Yes" to any question, please specify details	Yes	No	Don't Know
1	Is the patient sick today or has moderate/severe illness (e.g., fever)?			
2	Have you received a dose of COVID-19 vaccine? If yes, when: Date: ____/____/_____ Which product: ☐ Pfizer ☐ Moderna ☐ Another product_____			
3	Have you ever had a severe allergic reaction (anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen or for which you had to go to the hospital?			
	3a Was the severe allergic reaction after receiving COVID-19 vaccines? Or to any component in the COVID-19 vaccine?			
	3b Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4	Does the patient have allergies to medications (oral)? If yes, please specify:			
5	Does the patient have a history of allergies to food, pet, insect, venom, environmental, latex, or other allergies not related to vaccines or injectable therapies? Specify:			
6	Has the patient had a seizure or other neurological disorder? Specify:			
7	Does the patient have any long-term health problem with heart disease, lung disease, asthma, kidney disease, diabetes, anemia or other blood disorder/ bleeding disorder or is on blood thinner? Specify:			
8	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? Specify:			
9	Has the patient taken cortisone, prednisone, other steroids, or anti-cancer or medications or treatments that suppress the immune system?			
10	Has the patient ever been paralyzed by the Guillain-Barré Syndrome?			
11	Females: Are you pregnant or considering becoming pregnant in the next month?			
12	Females: Are you currently breastfeeding?			
13	Has the patient received any vaccinations in the past 14 days? Or plans to in the next 14 days? Specify:			
14	Has the patient been diagnosed with SARS-CoV-2 (Coronavirus) Infection? Date: ____/____/_____			
15	Has the patient been exposed to SARS-CoV-2 (Coronavirus) in the past 14 days? Date of Last Exposure: ____/____/_____			
16	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
17	Does the patient understand he/she must complete the same dose series, as the vaccine is not interchangeable with other COVID-19 vaccine products? If patient received another COVID-19 vaccine, Date: _____/_____/_____			

CONSENT FOR HEALTH SERVICES

I, the undersigned, understand that I will be fully informed of the need, risks, and advantages of each medical procedure and treatment, and do hereby give my free and full consent to the Department of Public Health and Social Services (DPHSS) to perform such necessary examinations and treatment deemed advisable in connection with my diagnosis and the maintenance of good health. I also understand that I have the right to refuse such care, unless required by law. I understand that it is my responsibility to supply accurate and complete medical history information to those involved with my care, and to inform them of any changes in my health. I also understand that it is my responsibility to inform those involved with my care if I do not understand any instructions given or cannot follow them. This consent, unless sooner revoked in writing, shall expire upon my discharge by appropriate authorities of DPHSS.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Department of Public Health and Social Services (DPHSS) Notice of Privacy Practices.

- It tells me how DPHSS will use my health information for the purposes of treatment, payment for my treatment, and health care operations.
- It explains in more detail how DPHSS may use and share my health information for other purposes other than treatment, payment, and health care payment.
- It tells me how DPHSS will use and share my health information as required/permitted by law.
- It explains my individual rights in regards to my health information.
- If I am a DPHSS consumer receiving health services, I consent to DPHSS using and disclosing my treatment and medical records maintained by DPHSS for the purpose detailed in the Notice of Privacy Practices.

_____ Signature / Date

_____ Witness Signature / Date

MUST BE SIGNED IN THE PRESENCE OF A PUBLIC HEALTH OFFICIAL