COVID-19 VACCINE SCREENING AND CONSENT FORM

Inspire Medical Group of California, PC: 333 West El Camino, Suite 230, Sunnyvale, CA 94087 **Age:** _____

SECTION 1: PATIENT INFORMATION (PLEASE PRINT)

LAST NAME	**FIRST NAME**	**MIDDLE INITIAL**
DATE OF BIRTH: MONTH DAY YEAR	**MOBILE PHONE NUMBER (PATIENT OR GUARDIAN)**	

MARITAL STATUS: ☐ Single ☐ Partnered ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

ADDRESS		**APT/ROOM #:**
CITY	**STATE**	**ZIP**
EMAIL ADDRESS	**PRIMARY DOCTOR'S NAME**	
LEGAL GUARDIAN: LAST NAME:	**FIRST NAME**	**MIDDLE INITIAL**

LEGAL SEX: ☐ Female ☐ Male ☐ Nonbinary

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other ☐ Pacific Islander ☐ White ☐ Other Asian ☐ Other Non-White ☐ Other Pacific Islander ☐ Unknown

SECTION 2: INSURANCE INFORMATION

☐ I opt to self-pay for the flu vaccine. (If selected, please proceed to Section 3)

PRIMARY INSURANCE CARRIER ID #: _____ **GROUP #:** _____

Insurance Company: _____ Insurance Company Phone Number: _____

Insured's Name: _____ Relationship: _____ Insured's Date of Birth: _____

SECONDARY INSURANCE CARRIER ID #: _____ **GROUP #:** _____

Insurance Company: _____ Insurance Company Phone Number: _____

Insured's Name: _____ Relationship: _____ Insured's Date of Birth: _____

SECTION 3: PRE-VACCINATION CHECKLIST FOR COVID-19 VACCINATION

The following questions will help us determine if there is any reason you SHOULD NOT get the COVID-19 vaccine today. **If you answer "YES" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, then please ask your healthcare provider to explain it.

1. Are you feeling sick today?	☐ YES ☐ NO ☐ DON'T KNOW
2a. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product(s) did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Other Product _____	☐ YES ☐ NO ☐ DON'T KNOW
2b. How many doses of COVID-19 vaccine have you received? ☐ FIRST Dose ☐ SECOND Dose ☐ Booster 1 ☐ Booster 2 ☐ Booster 3 ☐ _____	
2c. Did you bring your vaccination record card or other documentation?	☐ YES ☐ NO ☐ DON'T KNOW
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? (This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or highdose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant (HCT), or moderate or severe primary immunodeficiency.	☐ YES ☐ NO ☐ DON'T KNOW
4. Have you received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐ YES ☐ NO ☐ DON'T KNOW
5. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)	
▪ A component of COVID-19 vaccine	☐ YES ☐ NO ☐ DON'T KNOW
▪ A previous dose of COVID-19 vaccine	☐ YES ☐ NO ☐ DON'T KNOW
6. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)	☐ YES ☐ NO ☐ DON'T KNOW

7. Check all that apply to you:

☐ Have a history of myocarditis or pericarditis
☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
☐ Have a history of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
☐ Have a history of Guillain-Barré Syndrome (GBS)
☐ Have a history of COVID-19 disease within the past 14 days?

SECTION 4: PARTICIPANT/PARENTAL INFORMED CONSENT SIGNATURE

- 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 5 years of age; or (c) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to Inspire Medical Group of California, PC or its agents to administer the COVID-19 vaccine.
- I have received/read (or had read to me) the Vaccine Information Statement(s), Vaccine Information Fact Sheet(s) and or Patient Fact Sheet(s) regarding the vaccine(s). I understand the risks/benefits of vaccination. I voluntarily assume full responsibility for any reactions/consequences that may result. I understand that I should remain in the vaccination administration for 15 minutes, or longer if directed, for monitoring of potential adverse reaction. In the event of side effects, I understand that I should call my doctor. In the event of severe reaction, I understand to call 911.
- I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Inspire Medical Group of California, PC 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 Medical Group of California, PC 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 Medical Group of California, PC 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 Medical Group of California, PC 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 Medical Group of California, PC invoices me after the time of service, upon receipt of such invoice.

Signature of Patient (or parent / guardian): _____ **Date:** MONTH _____ DAY _____ YEAR _____

Print your Name: _____

For Administrative Use Only

Site/Route	Manufacturer	Lot #	Expiration Date	Dose
☐ RIGHT DELTOID IM ☐ LEFT DELTOID IM				

Administered by/Title: _____

Signature: _____

Print Name: _____

Date: MONTH _____ DAY _____ YEAR _____