Johnson & Johnson COVID-19 Vaccine Patient Acknowledgment Form

Patient Name (Last, First): _____ DOB: ____/____/_____

Phone/Mobile Phone: _____ Email: _____

Address: _____

City, State, Zip Code: _____ Married □ Single □

Primary Insurance Name:_____ Group #:_____

Secondary Insurance Name:_____Group #: _____

Information collected in this section helps ensure we deliver equitable and patient-centered care:
Sex listed at birth (check one): Male: □ Female: □

Gender Identity (Check one): Male: □ Female: □ Non-Binary: □ Unspecified/Indeterminant: □

Ethnicity (Check one):

Hispanic or Latino (Including Spanish, Mexican, Puerto Rican, Cuban, etc.) □	Not-Hispanic A person not of Spanish culture or origin □

Race: (Check all that apply):

Black or African American □	Asian □ American Indian or Alaska Native □	Hawaiian or Pacific Islander □ White □

Exclusion Questions: Answering yes to either of these questions excludes you from receiving the vaccine.

Do you have a known history of a severe allergic reaction (e.g. anaphylaxis) to this vaccine or any components of the vaccine including lipids, tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose. (Full list is available in the *Fact Sheet for Vaccine Recipients and Caregivers* or from your health care provider.)	Yes	No
Are you under the age of **18 years**?	Yes	No

Screening Questions: *Immunizer: If patient answers "yes" to any of the below, provide patient counseling or instruct them to consult with their caregiver prior to receiving the vaccine.*

In the past two weeks have you tested positive for COVID-19?	Yes	No
In the past two weeks have you had exposure to a person who tested positive for COVID-19 at a distance of six feet or less for a period of 15 or more minutes without wearing appropriate personal protective equipment?	Yes	No
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?	Yes	No
In the past 90 days have you received passive antibody therapy as part of COVID-19 treatment?	Yes	No
Are you pregnant or breastfeeding or do you plan to become pregnant?	Yes	No
Are you immune compromised or on a medicine that affects your immune system?	Yes	No
Do you have a bleeding disorder or are you on a blood thinner?	Yes	No
Do you have a history of severe allergic reaction (e.g. anaphylaxis) to another vaccine or injectable medication? If yes, what vaccine or injectable medication: _____	Yes	No

Acknowledgements:

- *I made the choice to get the COVID-19 vaccine on my own and freely. I know I have the option to refuse the vaccine. I ask that the vaccine be given to me, or to the person named above for whom I can make this request. I was given the (Fact Sheet for Vaccine Recipients and Caregivers)* for this vaccine. The fact sheet *has information about side effects and adverse reactions. I read or had read to me the information provided about the COVID-19 vaccine.*

- *I know the Food and Drug Administration (FDA) has authorized the emergency use of this vaccine. I know it is not a fully licensed FDA vaccine. I had the chance to ask questions that were answered to my satisfaction. I now know about the vaccine, alternatives, benefits, and risks, to the extent they are known and unknown at this time.*

- *I know that I must stay in the vaccine area or an area told to me by my health care provider after I receive my immunization so I am near my health care provider if I have any adverse reactions. If I have a history of severe allergic reaction, (e.g. anaphylaxis), I must stay for 30 minutes. If I do not have a history of severe allergic reaction, I must stay for 15 minutes*

- *I know that if I have a severe allergic reaction, including difficulty breathing, swelling of my face and/or throat, a fast heartbeat, a bad rash all over my body or dizziness and weakness I should call 9-1-1 or go to the nearest hospital. I know I can call my health care provider if I have any side effects that bother me or do not go away.*

- *I was asked to join the V-SAFE program. The program does health checks on the people who get the COVID-19 vaccine. I know I should report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 or https://vaers.hhs.gov/reportevent.html.*

- *I know that with all vaccines there is no promise I will become immune (not get the virus) or that I will not have side effects.*

Disclosure of Records: *I understand the organization providing my vaccine may be required to or may voluntarily disclose my vaccine-related health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also understand the organization providing my vaccine will use and disclose my health information as described in its Notice of Privacy Practices which I may receive upon request or find on its website.*

Patient (or Parent/Guardian/Authorized Representative) Signature:* _____ Date: _____
By signing here I also attest that I fall within the vaccination category being provided today.

Name of Parent, Guardian or Authorized Representative: _____ Date: _____

If you are signing on behalf of the patient, you are stating that you are authorized to make the required decisions on behalf of the patient.

Notes about this form:

- **This form should only be provided to a patient if it is accompanied by the Fact Sheet for Vaccine Recipients and Caregivers https://www.fda.gov/media/146305/download**
- This form should only be used by clinicians well versed in the CDC's provider education materials who are able to counsel patients who answer "yes" to the screening questions or make referrals for counseling for those patients.
- This form is intended as a resource. It is not a mandatory form.
- This form was developed based on the best available information at the time it was created. Its accuracy is not guaranteed. Organizations and individuals choosing to use this form should do so in consultation with their own clinicians and attorneys.
- This form is subject to update without notice. The most recent version of the form may be found on the WSHA website here: www.wsha.org/for-patients/coronavirus/coronavirus-resources-for-hospitals/
- For convenience, some elements in this form may be pre-recorded in electronic health records or other databases.
- Resources used in creating this form:
  - Fact Sheet for Health Care Providers Administering Vaccine: https://www.cdc.gov/vaccines/covid-19/info-by-product/janssen/index.html

  Fact Sheet for Vaccine Recipients and Caregivers: https://www.fda.gov/media/146305/download
  - V-Safe Program; https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafe.html
  - COVID-19 Vaccination Communication Toolkit: https://www.cdc.gov/vaccines/covid-19/health-systems-communication-toolkit.html
  - Washington State's COVID-19 Vaccine Plan for vaccine reporting requirements. https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/WA-COVID-19-Vaccination-Plan.pdf
  - For Demographic Information:
    - Washington State CHARS Manual: https://www.doh.wa.gov/Portals/1/Documents/5300/CHARSManual-UB04-5010.pdf
    - Race Ethnicity Language Data Collection Best Practices: http://forces4quality.org/af4q/download-document/6011/Resource-validated_final_rel_data_collection_best_practice_guidelines_updated_11-28.pdf

  Collecting Sexual Orientation and Gender Identity Information: https://www.cdc.gov/hiv/clinicians/transforming-health/health-care-providers/collecting-sexual-orientation.html

Johnson & Johnson Lot#:_____ Date administered:_____

LEFT DELTOID:_____ RIGHT DELTOID:_____ Initials:_____