DETROIT PUBLIC SCHOOLS COMMUNITY DISTRICT

Fisher Building • 3011 West Grand Blvd. • Detroit, MI 48202

detroitk12.org

COVID-19 Vaccine Patient Intake Form

Patient Name: _____ Birthdate: _____ Age: _____

School Name: _____ Grade: _____

Parent/Guardian Name (if applicable): _____

Gender (circle one): Male / Female / Other _____ Assigned Sex at Birth (circle one): Male / Female

Race/Ethnicity: □Caucasian □Black/AA □American Indian/Alaskan Native □Asian □Other_____ □Unknown

Hispanic Ethnicity: □ Hispanic/Latino □Non-Hispanic/Latino □Unknown

Arab Ethnicity: □Arab □non-Arab □Unknown Does child have a **disability**? □Yes □No □Prefer not to reply

Street Address: _____ City, State, Zip: _____

Telephone: _____ Cell / Home / Other

Insurance Type (circle): Private / Medicaid / No Insurance

Screening for COVID-19 Vaccine Eligibility	**YES**	**NO**
(1) Is the patient sick today (e.g., moderate, or severe illness)?		
(2) Has the patient ever received a dose of COVID-19 vaccine? If yes, which product and date? Pfizer _____ Another Product _____ If yes, did the patient bring a vaccination record card or other documentation? Yes / No		
(3) Has the patient ever had an allergic reaction to: ❑ A component of a COVID-19 vaccine, including either of the following: - polyethylene glycol (PEG), which is found in some medications, such as laxatives and preps for colonoscopy procedures - polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids ❑ A previous dose of COVID-19 vaccine ❑ A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 component, but it is not known which component elicited the immediate reaction ❑ 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 EPI PEN or that caused you to go to the hospital. It would also*		

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include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)		
(4) Has the patient ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.		
(5) Does the patient have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside of the heart)?		
(6) Has the patient ever had COVID-19 and been treated with monoclonal antibodies or convalescent plasma?		
(7) Does the patient have a weakened immune system caused by something such as HIV infection or cancer? Or Does the patient take immunosuppressive drugs or therapies?		
(8) Does the patient have a bleeding disorder or take a blood thinner?		
(9) Is the patient pregnant or breastfeeding?		
(10) Has the patient ever had Guillain-Barré Syndrome?		

Parent/Guardian (Please Print): _____

Parent/Guardian Signature: _____ Date: _____

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HIPAA Acknowledgement and Informed Consent and Consent for COVID-19 Vaccination

HIPAA and Informed Consent

1. I have received the COVID-19 Emergency Use Authorization Recipient and Caregiver Fact Sheet.
2. I understand that the Detroit Public Schools Community District will enter my immunization status information into MCIR (Michigan Care Improvement Registry). The Emergency Use Authorization Fact Sheet reviews the ways in which Detroit Public Schools Community District may use and share my immunization information with MCIR.
3. As allowed by law, I give permission for the Detroit Public Schools Community District to use and share my information for the purposes stated in the Emergency Use Authorization Fact Sheet. I understand that my personal health information will not be shared with or sold to third parties.
4. I have the right to ask the Detroit Public Schools Community District to control the way my protected health information is used or shared to carry out treatment, payment, or healthcare operations. The Detroit Public Schools Community District does not have to agree.
5. At all times, I have the right to cancel this Consent. If I want to **cancel,** I must submit a letter to or call the Detroit Public Schools Community District school in which the student is enrolled. Please follow this link (www.detroitk12.org) to find your school's contact information. The cancellation will be effective immediately when the letter is given to the Detroit Public Schools Community District, except if the Detroit Public Schools Community District has already taken action that uses the Consent.

Consent for COVID-19 Vaccination

I have read, or have had explained to me, the information contained in the *Emergency Use Authorization Fact Sheet for Recipients and Care Givers* for the COVID-19 vaccine (available online at www.michigan.gov/mdhhs), and understand the risks and benefits of the vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the risks and benefits of the vaccine requested and ask that the COVID-19 vaccine be given to me or to the person named above for whom I am authorized to make this request. I understand that a record of this immunization is required to be entered into MCIR (Michigan Care Improvement Registry) and will also be shared with other health care providers directly involved with the vaccinated person's care. This consent form authorizes the administration of multiple doses of a vaccine, if medically indicated. Combination vaccines will be used as available, unless contraindicated. This consent form will expire after the last vaccination is given in a vaccine series.

I HAVE READ AND UNDERSTAND THIS INFORMATION. MY SIGNATURE VERIFIES THAT I HAVE RECEIVED A COVID-19 VACCINE EMERGENCY USE AUTHORIZATION AND/OR A VACCINATION INFORMATION SHEET(S). I AM EITHER THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ Date: _____

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FOR ADMINISTRATIVE USE ONLY

Parent Consent Confirmation

❑ *Parent was present (if not, please fill table below)*
❑ *Parent/guardian was contacted and confirmed their consent for DPSCD to provide the COVID-19 vaccine to their child.*

Date & Time of Call	***Parent/Guardian Name***	***Staff Name (Of Caller)***

Vaccine	**Date Dose Administered & EUA Given**	**Route**	**Site (Circle one)**	**Dose (MLs)**	**Lot Number**	**EUA**
Pfizer-BioNTech COVID-19 Vaccine		IM	LA RA			
Moderna COVID-19 Vaccine		IM	LA RA			

Signature and Title of Vaccine Administrator: _____ Date: _____

Station #: _____

General Notes:

For Data Entry Staff to Complete:

Location Name (clinic location)	**Patient's MCIR ID #**	**Dose Number (circle one)**
		1st Dose 2nd Dose 3rd Dose