Pfizer COVID-19 Vaccine Screening Form

PROJECT VISION HAWAI'I
dba Hawaiian Eye Foundation

Section 1:

RECIPIENT'S NAME (Last)	(First)	(M.I.)	**RECIPIENT'S DATE OF BIRTH** **Month**_____ **Day**_____ **Year**_____
RECIPIENT OR AUTHORIZED POA EMAIL			**RECIPIENT OR AUTHORIZED POA PHONE NUMBER**
RECIPIENT ADDRESS			**RECIPIENT'S AGE** / **RECIPIENT'S GENDER** ☐ Female ☐ Male ☐ Other ☐ Decline to specify
CITY	**STATE**	**ZIP**	

RECIPIENT'S RACE (Check all the apply)

☐ Black ☐ White ☐ Native American/Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander, specify _____
☐ Hispanic ☐ Other race, specify _____
☐ Filipino ☐ Japanese ☐ Chinese ☐ Other Asian, Specify _____

Where did you sleep last night? Homeless status? Y N Observation:	Shelter, Facility, Encampment, Program: Staff or Client?

Section 2:

Have you been previously vaccinated with any COVID-19 Vaccine ☐Yes ☐No

If Yes, Product Name:_____ Date Received: _____
(must provide written documentation of previous vaccination with product type)

If vaccine product Pfizer COVID-19 Vaccine **AND** at least 21 days since date received, proceed to Section 3.

If vaccine product NOT Pfizer COVID-19 Vaccine, **STOP**. Pfizer COVID-19 vaccine will not be administered.

Section 3: Screening Questions to determine if you may be vaccinated today

	Yes	No
1. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to a vaccine, any component of thisor other vaccines, or to any injectable medication (intramuscular, intravenous, or subcutaneous)?	☐	☐
2. Do you have a history of a severe allergic reaction (e.g., anaphylaxis) to any medications, foods, pets,insects, venom, environmental triggers, or latex?	☐	☐

Section 4: Considerations from the CDC

Anyone 12 years and older is eligible for the Pfizer Vaccine

Administration of Pfizer COVID-19 Vaccine with other vaccines

- Covid-19 vaccines and other vaccines may now be administered without regards to timing. If multiple vaccines are administered at a single visit, administer each injection in a different injection site.
- Extensive experience with non-covid-19 vaccines has demonstrated that immunogenicity and adverse event profiles are generally similar when vaccines are administered simultaneously as when they are administered alone.

History of a previous or current COVID-19 infection

- You may receive a COVID-19 vaccine if you have had a previous COVID-19 infection.
- If you have a current COVID-19 infection, you should wait until you are better and have completed yourisolation time before coming in to get a COVID-19 vaccine.
- There is no recommended minimum time between recovering from a COVID-19 infection and getting aCOVID-19 vaccine.

History of unprotected exposure to a person who tested positive for COVID-19 in the last 14 days

- If you have had an unprotected COVID-19 exposure, you should wait to complete your quarantine beforecoming in to get a COVID-19 vaccine.

If you have been treated with a monoclonal antibody or convalescent plasma

- You should wait at least 90 days to get a COVID-19 vaccine after treatment with a monoclonal antibody or convalescent plasma for a COVID-19 infection.

Recipient Name (Last)_____(First)_____(Date of Birth)_____

Section 4: Continued

Special populations: If you are immunocompromised, pregnant, or breastfeeding

- A COVID-19 vaccine may be administered to immunocompromised individuals, including people with HIV andthose on immunosuppressive medications, but the vaccine has not been fully studied in this population.
- Any of the currently authorized COVID-19 vaccines can be administered to pregnant or lactating people; ACIP does not state a product preference. However, pregnant, lactating, and post-partum people aged <50 years should be aware of the rare risk of TTS after receipt of the Janssen COVID-19 vaccine and the availability of other FDA-authorized COVID-19 vaccines

If you have any additional questions after reviewing the above information, talk to your doctor or healthcareprovider before getting the PFIZER COVID-19 Vaccine.

Section 5: Acknowledgment & Consent

I, the undersigned, agree that Project Vision Hawai`i (PVH) may provide me with the medical services described above. I permit PVH to arrange for the clinical analysis, reporting and interpretation of these medical services. *I have been given a copy of the Fact Sheet for Recipients and Caregivers for the Emergency Use Authorization (EUA) of the Pfizer COVID-19 vaccine and have read it. I have had the chance to ask questions and I am satisfied with the answers and explanations given. I understand that this vaccine has not yet been approved by the Food and Drug Administration ("FDA"), and is being given under an FDA issued EUA. I understand the benefits and risks of this vaccine and ask that the vaccine be given to me, or the person for whom I am authorized to make this request. I understand that because this is not an FDA-approved vaccine but is being given under an FDA issued Emergency Use Authorization, the State of Hawaii, its departments, agencies andemployees ("the State") are immune from civil liability under federal and state law for all claims for loss related to any known or unknown side effects and/or injuries, including but not limited to death, that I, or the person for whom I am authorized to make this request, may experience from this vaccine. This immunity means that if I file a lawsuit against the State, the court must dismiss any such lawsuit, and the only exception to this immunity is for claims of willful misconduct. In addition, I have received information regarding the Hawaii Immunization Registry (see attached).*

I acknowledge the above and request the vaccine to be administered to me, or to the named recipient.

_____ _____
Recipient Name (Please Print) Date

_____ _____
Recipient Signature Date

_____ _____
Parent/Legal Guardian/POA Name (Please Print) Date

_____ _____
Signature of Parent/Legal Guardian/POA Date

For Clinic Use:
*Form Reviewed by*_____ *Clear to Vaccinate?* ☐ *Yes* ☐ *No*

Section 5: Vaccine documentation (DOH Use ONLY):

Vaccine	Dose #	Date Dose Administered	Dose Size	Site	Route	Vaccine Manufacturer	Lot Number	Exp. Date	Name, Address, and Title of Vaccine Administrator
Pfizer COVID-19	#1 #2	/ /	0.3 mL	RA LA	IM	Pfizer			

Vaccine Not Administered (Reason):

COVID-19 Vaccine

Consent and Authorization to Release Medical Record; Release of Liability

I. MEDICAL RELEASE Authorization

I hereby consent to and authorize (i) the disclosure of my completed Test to the Lab, in order to permit the Lab to analyze and interpret my Test,(ii) the disclosure of my Test results, in any manner permitted by federal or state privacy and security laws, to the following organizations: Partners in Care Manager and Homeless Management Information System (HMIS) Manager, located at 200 N. Vineyard Blvd., Ste 210, Honolulu, HI 96817; State of Hawai`i, Department of Health, Disease Outbreak Division, located at 1250 Punchbowl St., Rm 443, Honolulu, HI 96813, and the host facility: _____., located at _____, if applicable. This consent and authorization is valid the day this document is signed by me and expires after one (1) year.

II. Notice of Privacy Practices Acknowledgment

I understand under the Health Insurance and Portability and Accountability Act of 1996 (HIPAA), and Health Information Technology for Economic and Clinical Health Act of 2013 (HITECH) Omnibus Rule, I have certain rights to privacy regarding my protected health information. By signing this form, I ac

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers unless directly requested to withhold PHI from health plan and all healthcare services are paid in full by paying out of pocket.
3. Conduct normal healthcare operations such as quality assessments.
4. My consent and authorization will result in the use or disclosure of my protected health information (PHI). Though precautions will be taken to protect the confidentiality of my PHI, I understand the transmission of PHI presents risks and the confidentiality of such information may be compromised by failures of security safeguards or illegal tampering.

By signing this form, I acknowledge I have seen PVH's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand PVH has the right to change its Notice of Privacy Practices from time to time and I may contact the organization at any time to obtain a current copy of the Notice of Privacy Practices.

III. Waivers

In consideration for receiving the opportunity to receive the Test and considering I may administer this test to myself now or choose to have it administered to me, I hereby **RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE** Project Vision Hawai`i and the Hawaii Island Home for Recovery, Inc. located at 440 Kapiolani St., Hilo, HI 96720, and its officers, servants, agents, employees, direct or indirect owners, or direct or indirect subsidiaries (the "Project Vision Hawai`i Releasees" and/or enter host site name ") from and against any and all **SUITS, ACTIONS, LOSSES, DAMAGES, CLAIMS, OR LIABILITY OR ANY CHARACTER, TYPE OR DESCRIPTION, INCLUDING ALL EXPENSES OR LITIGATIONS, COURT COSTS, AND ATTORNEY'S FEES FOR INJURY OR DEATH TO ANY PERSON, OR INJURY TO ANY PROPERTY, RECEIVED OR SUSTAINED BY ANY PERSON OR PERSONS OR PROPERTY, ARISING OUT OF, OR OCCASIONED BY, DIRECTLY OR INDIRECTLY, WHETHER CAUSED BY THE NEGLIGENCE OF THE PROJECT VISION HAWAI`I RELEASEES OR OTHERWISE, ADMINISTERING A TEST TO MYSELF (OR ADMINISTERED BY A PROJECT VISION HAWAI`I EMPLOYEE) OR MY PRESENCE ON SELECTED HOST PROPERTY TO OBTAIN A TEST.** I hereby accept and assume all risks to myself involved in the administering a test to myself (or administered to me) and fully assume all responsibility for injury, damage, or claim of any nature whatsoever that may result from such administration.

I certify that (i) this document has been completely explained to me; (ii) I read this document or someone read it to me; (iii) all of my questions regarding this document have been answered; and (iv) I completely understand this document.

Signature:_____ Date:_____/_____/_____

Print Name:_____ PVH Witness: _____

Relation to patient:_____ *If signed by someone other than the patient or parent of a minor child, please provide documents to show authority to release of patient's protected health information.*

HAWAII IMMUNIZATION REGISTRY INFORMATION

INFORMATION CONTAINED IN THE REGISTRY

- Immunization information including but not limited to vaccine type, date of vaccine administration, vaccine administration site and route, lot number, expiration date, patient's history of vaccine preventable diseases, contraindications, precautions, adverse reactions, and/or comments regarding vaccinations.
- Personal information including but not limited to an individual's first, middle, and last name, date of birth, gender, mailing address, phone number, parent/guardian name, parent/guardian relationship to the individual, their contact information, and mother's maiden name.

CONFIDENTIALITY AND PRIVACY INFORMATION

All authorized users and the Department of Health Immunization Branch acknowledge that the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (PL 104-191 and 45 CFR Parts 160 and 164, "Standards for Privacy of Individually Identifiable Health Information") governs the use and disclosure of individually identifiable information by entities subject to the Privacy Rule. Although HIPAA standards for privacy were used as a guide to assist in the development of the Registry Confidentiality and Privacy policies, the Registry and the Department of Health Immunization Branch are not "covered entities" under HIPAA. Providers, health plans and other covered entities who are authorized users must comply with the HIPAA Privacy Rule.

Registry information will be entered by and available to authorized users for authorized purposes only. All authorized users will be required to safeguard the privacy of patient participants by protecting confidential information in the Registry in accordance with the Hawaii Immunization Registry Confidentiality and Privacy Policy, the Hawaii Immunization Registry Security Policy, as well as all applicable State and Federal Laws.

AUTHORIZED USERS

Authorized users of the Registry may include individuals and/or entities that require regular access to patient immunization and other individually identifiable health information to provide immunization services to specific patients, maintain a computerized inventory of their public and private stock of vaccines, assess immunization status to determine immunization rates, and/or ensure compliance with mandatory immunization requirements. All authorized users are required to sign a Hawaii Immunization Registry Confidentiality and Security Statement indicating that they have received a copy of the Hawaii Immunization Registry Confidentiality and Privacy Policy and the Hawaii Immunization Registry Security Policy, understand the terms, including penalties for violation of the policies, and agree to comply with the policies.

The Department of Health Immunization Branch is responsible for oversight of the Registry and therefore will be designated as an authorized user.

USES OF REGISTRY INFORMATION (AUTHORIZED PURPOSES)

Registry immunization data and other individually identifiable health information shall be utilized by authorized users for the purposes of:

- Consolidating, maintaining, and accessing computerized immunization records;
- Consolidating and maintaining vaccine inventory information;
- Determining the immunization history of individuals and delivering health care treatment accordingly;
- Generating notices for individuals who are due or overdue for immunizations and in the event of a vaccine recall;
- Staying abreast of the complex immunization schedule by utilizing registry-supplied immunization forecasting tools;
- Assessing the immunization rate of their patient population (or subsets thereof);
- Generating official immunization records (e.g. Student's Health Record);
- Ensuring compliance with mandatory immunization requirements;
- Recording the distribution of prophylactic and treatment medications administered or dispensed in preparation for and in response to a potentially catastrophic disease threat;
- Complying with Hawaii Vaccines For Children and other State-provided vaccine programs' vaccine ordering and accountability policies and procedures; and
- Other purposes determined at the discretion of the Department of Health Immunization Branch.

Registry immunization data and other individually identifiable health information shall be utilized by the Department of Health Immunization Branch for the following public health purposes including but not limited to:

- Ensuring compliance with mandatory immunization requirements;
- Performing Quality Improvement/Quality Assessment activities;
- Complying with Hawaii Vaccines For Children and other State-provided vaccine programs' vaccine ordering and accountability policies and procedures;
- Preventing and managing outbreaks of vaccine-preventable diseases and other public health emergencies;
- Producing immunization assessment reports to aid in the development of policies and strategies to improve public health;
- Managing and maintaining the Registry system; and
- Other purposes determined at the discretion of the Department of Health Immunization Branch.

AVAILABILITY OF IMMUNIZATION RECORD INFORMATION

An individual's immunization data and other individually identifiable health information in the Registry will be made available to the individual's immunization provider, the Department of Health, and other Registry authorized users for authorized purposes only.

OPT-OUT

Individuals may choose not to include their or their child's immunization data in the Registry ("opt-out"). Individuals must opt-out in writing by completing a "Hawaii Immunization Registry Opt-Out Form" which is available from the individual's immunization provider or the Department of Health Immunization Branch. The Registry will retain only core demographic information necessary to identify the individual has chosen to opt-out of the Registry. This information is necessary to enable the Registry to filter and refuse entry of immunization information for the individual. Core demographic data will be for Hawaii Department of Health use only and will be non-displaying to all other Registry authorized users. An individual's decision not to authorize the inclusion of immunization data in the Registry will not affect whether or not they receive immunizations.

REVOCATION

An individual may revoke their decision to opt-out of the Hawaii Immunization Registry at any time. Revocations must be made in writing by completing a "Hawaii Immunization Registry Reauthorization Form" obtained from the individual's immunization provider or the Department of Health Immunization Branch.

RIGHT TO INSPECT, COPY, CORRECT OR AMEND PERSONAL AND IMMUNIZATION INFORMATION

Individuals may inspect, copy, correct or amend their or their child's immunization record information via their or their child's immunization provider. For information on how to inspect, copy, correct or amend your or your child's information, please speak with your doctor.

QUESTIONS?

If you have any questions about the Registry, please speak with your doctor or visit our website at: http://health.hawaii.gov/docd/hawaii-immunization-registry/.