For official use: IM SC **L R** W B A P O H **Lot:** _____
Date: _____ **Exp:** _____

COVID-19 2nd Booster Shot Consent Form

Last name: _____ First Name: _____

Date of Birth: _____ / _____ / _____ Email address: _____

Home address: _____Mobile Phone # : _____

Medicare #: Or Social Security Number:

				-				-							-		-				

Eligibility

Per CDC recommendation, 2nd booster shot is offered only to 50 years and older. Are you 50 or over? Yes No

Have you received J&J/Janssen COVID19 vaccine for both Primary and booster? N/A Yes No

CDC recommends at least 4 months after your first booster. When was your last booster? _____/ _____/ _____

Pre-screening Questionnaire (encircle appropriate selection) X= no ✓= yes

Are you feeling sick today? X ✓
Have you ever had an allergic reaction to a component of a COVID-19 vaccine PEG, polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids or a previous dose of COVID-19 vaccine? X ✓
Have you ever had an allergic reaction to another vaccine (other than COVID19 vaccine) or an injectable medication? X ✓

Check all that apply:

Have a history of myocarditis or pericarditis? X ✓
Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies? X ✓
Had COVID-19 and was treated with monoclonal antibodies or convalescent serum? X ✓
Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection? X ✓
Have a bleeding disorder? X ✓ Take a blood thinner? X ✓
Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies? X ✓
Have a history of heparin-induced thrombocytopenia (HIT) X ✓ Am currently pregnant or breastfeeding? X ✓
Have received dermal fillers? X ✓ History of Guillain-Barré Syndrome (GBS)? X ✓

Consent

I have had an opportunity to ask questions, which have been answered to my satisfaction. I understand the risks and benefits of receiving the COVID-19 vaccine and request that the vaccine be given to me / the person for whom I am the legal representative. I understand that my vaccination will be entered into the local California Immunization Registry (CAIR), which will allow for coordinated care between my health care providers.

Notice of Privacy Practices

I hereby acknowledge receipt of the Notice of Privacy Practices (NPP) of Botika LTC. Our NPP gives you information about how we may use and disclose your medical or protected health information. Our NPP is subject to change. If we change our notice, we will post the revised version in our facilities and on our website here: https://botikaltc.com/hipaa-privacy-notice

I certify that I am the patient, the patient's legal representative, or otherwise authorized by the patient to sign the above and accept its terms on the patient's behalf.

Signature (patient or legal representative): _____

Patient Name: _____ Date: _____
Parent/Guardian printed name (if applicable): _____

If not patient, indicate relationship to patient: _____