BLOCKIT COVID-19 CUSTOM FORMS TEMPLATE RECOMMENDATION - CDC 1-22-21

Link Sharing - Fraud Avoidance

I UNDERSTAND THAT VACCINE SUPPLY IS CURRENTLY LIMITED AND THEREFORE SUBJECT TO STRICT PRIORITIZATION IN ACCORDANCE WITH CENTERS FOR DISEASE CONTROL AND STATE DEPARTMENT OF HEALTH DIRECTIVES. WITH THAT UNDERSTANDING, AND WITH THE UNDERSTANDING THAT I WILL HAVE TO SUPPLY PROOF OF ELIGIBILITY, I HEREBY CERTIFY UNDER PENALTY OF LAW THAT I HAVE RECEIVED AND INVITATION TO SCHEDULE MY VACCINATION APPOINTMENT DIRECTLY FROM [ORGANIZATION].
YES

I UNDERSTAND THAT NOT BELONGING TO CURRENT PRIORITY GROUPS OR PROCEEDING WITH SCHEDULING WITHOUT HAVING A DIRECT INVITE LINK FROM [ORGANIZATION NAME] WILL MAKE ME INELIGIBLE TO SCHEDULE A VACCINE AND I WILL BE REFUSED VACCINATION SERVICES UPON ARRIVAL.
YES

I UNDERSTAND THAT USING A LINK TO SCHEDULE MY VACCINATION PROVIDED TO ME THROUGH ANY OTHER SOURCE OTHER THAN [ORGANIZATION NAME] WILL MAKE ME INELIGIBLE TO RECEIVE THE VACCINE UPON MY ARRIVAL. EVEN IF AN APPOINTMENT IS MADE THROUGH THE ELECTRONIC SYSTEM.
YES

SECTION 1: COVID-19 DEMOGRAPHICS ADDITIONS TO BASE
RACE
AMERICAN INDIAN OR ALASKA NATIVE
ASIAN
BLACK OR AFRICAN AMERICAN
NATIVE HAWAIIAN
OTHER PACIFIC ISLANDER
WHITE
MULTI RACIAL
OTHER (PLEASE SPECIFY)

DECLINE TO ANSWER

RACE (OTHER)

ETHNICITY
HISPANIC
NON HISPANIC
PATIENT REFUSED
UNKNOWN

ARE YOU:
65 YEARS OF AGE OR OLDER OR
A HEALTHCARE WORKER THAT MEETS THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES' PHASE 1A DEFINITION OR
18 YEARS OF AGE AND OLDER WITH AT LEAST ONE CHRONIC MEDICAL CONDITION THAT PUTS YOU AT INCREASED RISK FOR SEVERE ILLNESS FROM THE VIRUS THAT CAUSES COVID-19?
YES
NO (INELIGIBLE)

SECTION 2: COVID-19 SCREENING QUESTIONS PLEASE CHECK YES OR NO FOR EACH QUESTION.

1. DO YOU HAVE TODAY OR HAVE YOU HAD AT ANY TIME IN THE LAST 10 DAYS A FEVER, CHILLS, COUGH, SHORTNESS OF BREATH, DIFFICULTY BREATHING, FATIGUE, MUSCLE OR BODY ACHES, HEADACHE, NEW LOSS OF TASTE OR SMELL, SORE THROAT, CONGESTION OR RUNNY NOSE, NAUSEA, VOMITING, OR DIARRHEA?
YES (INELIGIBLE)
NO

2. HAVE YOU TESTED POSITIVE FOR AND/OR BEEN DIAGNOSED WITH COVID-19 INFECTION WITHIN THE LAST 10 DAYS?
YES (INELIGIBLE)
NO

3. HAVE YOU HAD A SEVERE ALLERGIC REACTION (E.G. NEEDED EPINEPHRINE OR HOSPITAL CARE) TO A PREVIOUS DOSE OF THIS VACCINE OR TO ANY OF THE INGREDIENTS OF THIS VACCINE?
YES (INELIGIBLE)
NO

4. HAVE YOU HAD ANY OTHER VACCINATIONS IN THE LAST 14 DAYS (E.G. INFLUENZA VACCINE, ETC.)?
YES
NO

5. HAVE YOU HAD ANY COVID-19 ANTIBODY THERAPY WITHIN THE LAST 90 DAYS (E.G. REGENERON, BAMLANIVIMAB, COVID CONVALESCENT PLASMA, ETC.)
YES (INELIGIBLE)
NO

SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE
PLEASE CHECK YES OR NO FOR EACH QUESTION.

6. DO YOU CARRY AN EPI-PEN FOR EMERGENCY TREATMENT OF ANAPHYLAXIS AND/OR HAVE ALLERGIES OR REACTIONS TO ANY MEDICATIONS, FOODS, VACCINES OR LATEX?
YES
NO

7. FOR WOMEN, ARE YOU PREGNANT OR IS THERE A CHANCE YOU COULD BECOME PREGNANT?
YES
NO

8. FOR WOMEN, ARE YOU CURRENTLY BREASTFEEDING?
YES
NO

9. ARE YOU IMMUNOCOMPROMISED OR ON A MEDICATION THAT AFFECTS YOUR IMMUNE SYSTEM?
YES
NO

10.DO YOU HAVE A BLEEDING DISORDER OR ARE YOU ON A BLOOD THINNER/BLOOD-THINNING MEDICATION?
YES
NO

11.HAVE YOU RECEIVED A PREVIOUS DOSE OF ANY COVID-19 VACCINE?
YES
NO

IF YES PLEASE PROVIDE DATE: _____

IF YES, WHICH MANUFACTURER'S VACCINE DID YOU RECEIVE:
__Moderna
__Pfizer
__Other

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 18 YEARS OF AGE; OR (C) AUTHORIZED TO CONSENT FOR VACCINATION FOR THE PATIENT NAMED ABOVE. FURTHER, I HEREBY GIVE MY CONSENT TO THE FLORIDA DEPARTMENT OF HEALTH (DOH) OR ITS AGENTS TO ADMINISTER THE COVID-19 VACCINE.
YES
NO (INELIGIBLE)

I UNDERSTAND THAT THIS PRODUCT HAS NOT BEEN APPROVED OR LICENSED BY FDA, BUT HAS BEEN AUTHORIZED FOR EMERGENCY USE BY FDA, UNDER AN EUA TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) FOR USE IN INDIVIDUALS 18 YEARS OF AGE AND OLDER; AND THE EMERGENCY USE OF THIS PRODUCT IS ONLY AUTHORIZED FOR THE DURATION OF THE DECLARATION THAT CIRCUMSTANCES EXIST JUSTIFYING THE AUTHORIZATION OF EMERGENCY USE OF THE MEDICAL PRODUCT UNDER SECTION 564(B)(1) OF THE FD&C ACT UNLESS THE DECLARATION IS TERMINATED OR AUTHORIZATION REVOKED SOONER.
YES
NO (INELIGIBLE)

I UNDERSTAND THAT IT IS NOT POSSIBLE TO PREDICT ALL POSSIBLE SIDE EFFECTS OR COMPLICATIONS ASSOCIATED WITH RECEIVING VACCINE(S). I UNDERSTAND THE RISKS AND BENEFITS ASSOCIATED WITH THE ABOVE VACCINE AND HAVE RECEIVED, READ AND/OR HAD EXPLAINED TO ME THE EMERGENCY USE AUTHORIZATION FACT SHEET ON THE COVID-19 VACCINE I HAVE ELECTED TO RECEIVE.
YES
NO (INELIGIBLE)

I ALSO ACKNOWLEDGE THAT I HAVE HAD A CHANCE TO ASK QUESTIONS AND THAT SUCH QUESTIONS WERE ANSWERED TO MY SATISFACTION. • I ACKNOWLEDGE THAT I HAVE BEEN ADVISED TO REMAIN NEAR THE VACCINATION LOCATION FOR APPROXIMATELY 15 MINUTES (OR MORE IN SPECIFIC CASES) AFTER ADMINISTRATION FOR OBSERVATION. IF I EXPERIENCE A SEVERE REACTION, I WILL CALL 9-1-1 OR GO TO THE NEAREST HOSPITAL.
YES
NO (INELIGIBLE)

I ACKNOWLEDGE THAT: (A) I UNDERSTAND THE PURPOSES/BENEFITS OF MY STATE'S,IMMUNIZATION REGISTRY AND (B) DOH WILL INCLUDE MY PERSONAL IMMUNIZATION INFORMATION IN THE STATE REGISTRY AND MY PERSONAL IMMUNIZATION INFORMATION WILL BE SHARED WITH THE CENTERS FOR DISEASE CONTROL (CDC) OR OTHER FEDERAL AGENCIES.
YES
NO (INELIGIBLE)

I FURTHER AUTHORIZE THE VACCINE PROVIDER 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 DOH 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 DOH INVOICES ME AFTER THE TIME OF SERVICE, UPON RECEIPT OF SUCH INVOICE.
YES
NO (INELIGIBLE)

Txt Notifications and Reminders

Reminder
When: Day of appointment (6 Hours Prior)
Text: This message is a reminder from CLIENT team that you have a vaccination appointment at LOCATION on MONTH, DAY at TIME. See you soon!

Notifications
When: Appointment is scheduled
Text: This message is from the CLIENT team confirming your vaccination appointment at LOCATION on MONTH, DAY at TIME. See you then!

When: Appointment Canceled
Text: This message is from the CLIENT team confirming your vaccination appointment at LOCATION on MONTH, DAY at TIME has been canceled. Please reschedule your appointment at WEB ADDRESS.

When: Appointment No show
Text: This message is from the CLIENT team confirming your vaccination appointment at LOCATION on MONTH, DAY at TIME was missed. Please reschedule your appointment at WEB ADDRESS

When: Fulfilled
Text: This message is from the CLIENT team confirming your vaccination appointment at LOCATION on MONTH, DAY at TIME has been completed. Please reschedule your second dose appointment at WEB ADDRESS