Get vaccinated.
Get your smartphone.
Get started with v-safe.

Use your smartphone to tell CDC about any side effects after getting the COVID-19 vaccine. You'll also get reminders if you need a second vaccine dose.

When you get your COVID-19 vaccination, ask your healthcare provider about getting started with v-safe

Learn more about **v-safe**
www.cdc.gov/vsafe

CDC

12/01/20

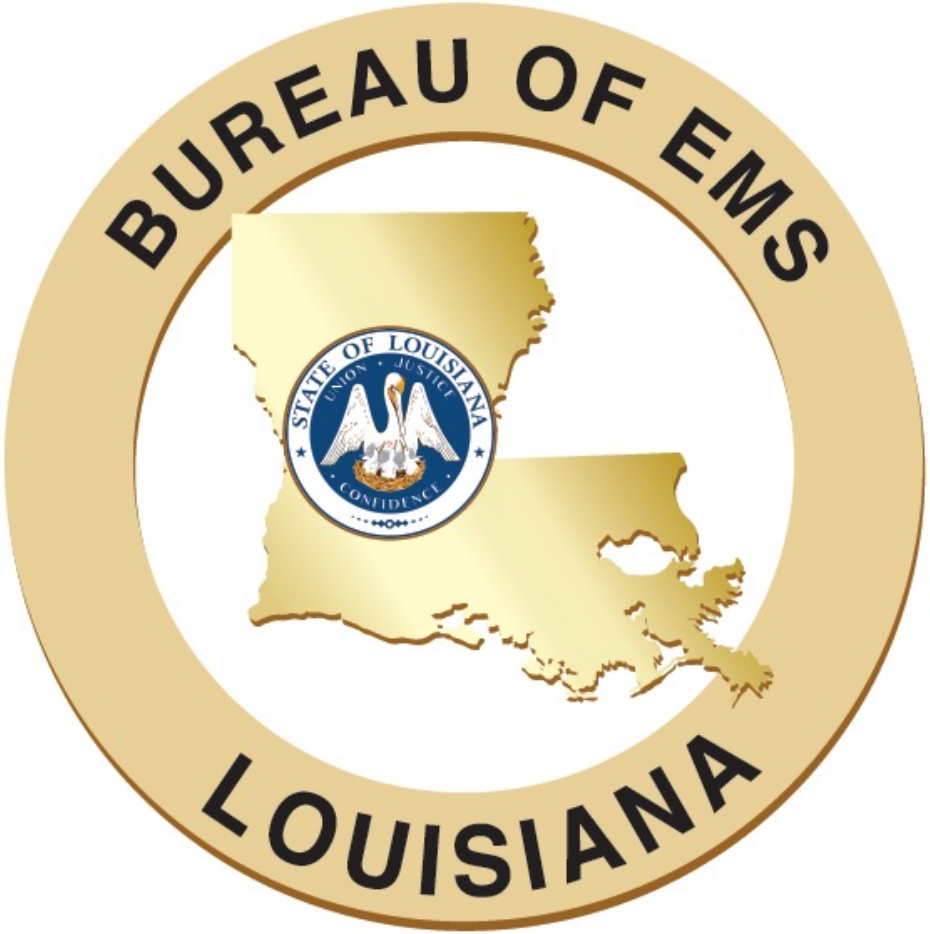
VACS FACTS

EMS PRACTITIONERS

FIRE DEPARTMENTS

FIRST RESPONDERS

FRONT LINE HEALTH CARE WORKERS



MORDERNA PRODUCT

KNOWN

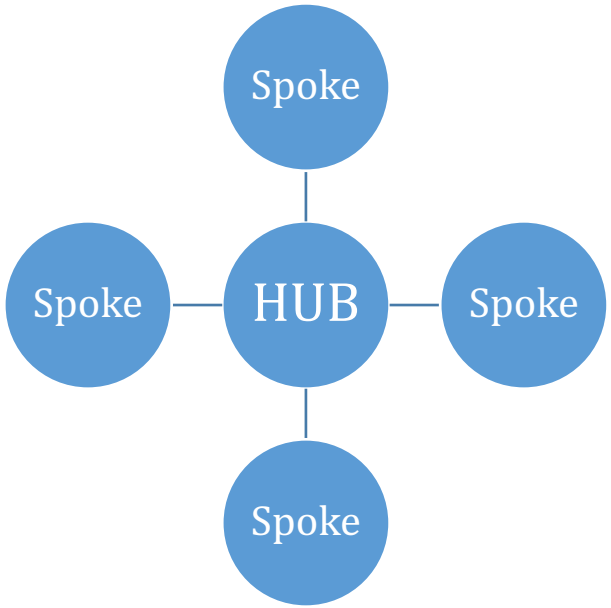
- Does not have to be ultra frozen
- Can be sorted in a regular freezer
- Cannot be stored with food or other items
- Expected availability date – December 21

UNKNOWN

- How quickly it must be used after taken out of freezer
  - Pfizer is 5 days
- How quickly it must be used after vial is punctured
  - Pfizer is 5 hours

LOUISIANA DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

DISTRIBUTION PLAN



- HUBs are **enrolled** EMS Providers and Fire Departments
  - Will be asked to be a HUB
- Spokes are others that will come to the HUB to receive the vaccine
  - Bureau of EMS staff and contractors will be available to assist the HUBs, if needed
- HUBs will assign the date and time that the vaccine will be available

LOUISIANA DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

FREQUENTLY ASKED QUESTIONS

- How do I enroll?
  - There are 3 forms that must be completed. They can be found at the following links
    - https://lalinks.org/linksweb/docs/LA_CDC_Supplemental_COVID-19_Vaccine_Admin_Redistribution_Agreement_10.28.2020.pdf
    - https://lalinks.org/linksweb/docs/LA_CDC_COVID-19_Vaccination_Program_Provider_Agreement_11.16.2020.pdf
    - https://lalinks.org/linksweb/
  - The forms are not binding and the number of vaccines will be confirmed prior to the delivery date
  - Administrator, Medical Director, and Financial Officer signature required

LOUISIANA DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

FREQUENTLY ASKED QUESTIONS

- If I enroll, what paperwork is involved?
  - Information must be put into LaLinks
    - This is the same process that is used that receiving a flu shot
  - The Bureau of EMS has developed a consent form template, although not required
    - This forms collects the information that is required in LaLinks

LOUISIANA DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

FREQUENTLY ASKED QUESTIONS

- Can I get a healthcare facility to administer the vaccine to my employees after getting from this distribution?
  - Yes. However, the healthcare facility must be enrolled in the program
  - The vaccine can only be transferred to a facility/agency that is enrolled
- Can I be a HUB but select my spokes?
  - Yes. You can select specific departments to be spokes

LOUISIANA DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

FREQUENTLY ASKED QUESTIONS

- I don’t want to be enrolled, but employees what the vaccine. How can they get it?
  - They will be permitted to go to a HUB.
  - Information on the date and time will be provided to the EMS Provider contact person

LOUISIANA DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

FREQUENTLY ASKED QUESTIONS

- What are the side effects? Should I expect employees to call in sick?
  - 5%-20% of recipients have side effects that range from a sore arm, low grade fever and fatigue that could cause employees to not be up to working the day after receiving the vaccine
  - It is best to prepare to administer the vaccine at the end of shift when the employee will be scheduled off the next day
    - This scheduling will be assigned by the HUBS only

LOUISIANA DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

FREQUENTLY ASKED QUESTIONS

- My family member wants one. Can they get it?
  - We have been instructed to not waste any vaccine. If there is a vial that has extra doses in it, they can be given to anyone
  - We have been told to “find an arm”

LOUISIANA DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

WHO IS ENROLLED?

- A-Med Ambulance (in progress)
- Acadian Ambulance
- Bossier Parish EMS
- Caddo Parish FPD 3
- Caddo FPD 4
- Cameron Parish ASD 2 (in progress)
- DeSoto Parish EMS (in progress)
- East Jefferson Hosp EMS
- Franklin Fire Department (in progress)
- Gretna Police EMS (in progress)
- Med Express Ambulance (in progress)
- Ruston Fire Department (in progress)
- St. Tammany FPD 4 (in progress)
- Ward 5 Fire Dept (in progress)

LOUISIANA DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services

Consent for COVID-19 Vaccination

You Agency's Logo Here

SECTION A Please print clearly.

First name:_____ Last name:_____

Date of birth:_____ Age_____ Gender: ☐ Female ☐ Male Phone:_____

Home address:_____ City:_____

State:_____ ZIP code:_____ Email address:_____

Doctor/primary care provider name:_____

Address:_____ City:_____ State:_____ ZIP code:_____

☐ I want to receive the COVID-19 vaccine.

SECTION B The following questions will help to determine your eligibility to be vaccinated today.

1. Do you feel sick today? ☐ Yes ☐ No ☐ Don't know
2. Do you have any health conditions, such as heart disease, diabetes or asthma? If yes, please list: ☐ Yes ☐ No ☐ Don't know
3. Do you have allergies to latex, medications, food or vaccines? If yes, please list: ☐ Yes ☐ No ☐ Don't know
4. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? ☐ Yes ☐ No ☐ Don't know
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barre syndrome (a condition that causes paralysis) or other nervous system problem? ☐ Yes ☐ No ☐ Don't know
6. **For women:** Are you pregnant or considering becoming pregnant in the next month? ☐ Yes ☐ No ☐ Don't know

SECTION C

I certify that I am: (a) that patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the Your Agency's Name Here and the licensed healthcare professional administering the vaccine to administer the COVID-19 vaccine. I understand that it is not possible to predict all possible side effects or complications associated with receiving the vaccine. I understand the risks and benefits associated with the vaccine and have received, read and/or had explained to me the vaccine information. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of myself, my heirs and personal representatives; I hereby release and hold harmless each Provider; its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the COVID-19 vaccine. I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("state Registry") and my state's health information exchange ("State HIE"); and (b) the Provider may disclose my vaccination information to the State Registry; to the State HIE; or through the State HIE to the State Registry, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my vaccination information to or through the State HIE as required or permitted by law. I also authorize the Provider to disclose my, or my child's proof of vaccination to the school where I am, or my child is a student or prospective student.

Patient Signature:_____ Date:_____

(Parent or guardian, if minor)

SECTION D HEALTHCARE PROVIDER ONLY

Complete BEFORE vaccine administration

1. I have reviewed the **Patient Information** and **Screening Questions**. Initial here: _____

2. This vaccine is appropriate for this patient based on the **Age Guidelines** provided by federal and/or state regulations and company policies. Initial here: _____

3. Dows this patient have a **high-risk medical condition**?
   If yes, please list medical condition(s):_____ Initial here: _____

Lot #:_____ Expiration Date:_____

SECTION E

Complete DURING the patient interaction

1. I have asked the patient to confirm their Name and DOB and verified it matches the information on the VAR form. Initial here: _____

2. I have reviewed the Screening Questions with the patient. Initial here: _____

SECTION F

Complete AFTER vaccine administration

Manufacturer	Dosage	Site of Administration

Clinician's name (print): _____ Clinician's Signature: _____

Title: _____ Administration Date: _____

Notes

Reminder

1. Input information into the LaLINKS