COVID Vaccine Intake Consent Form

Patient Information

Last Name	First Name	Date of Birth	Gender
Address	City	State	Zip
Email address	Phone Number		

If you are part of a Senior Facility clinic are you a resident? ____ or an employee/staff? ____
Is this your first dose? ____ Or your second dose of the COVID-19 vaccination?____

Insurance Information

If uninsured, you must check the box below to attest that the following information is true and accurate:

☐ I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government-funded health benefit plan.

Also if uninsured, in order to have your vaccine administration paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, you must provide either (a) a valid Social Security number, (b) state identification number and state of issuance or (c) a driver's license number and the state of issuance.

_____ or _____ or _____

Social Security Number | State Identification Number & State | Driver's License & State

COVID-19 Screening Questions	Yes	No
1. In the past two weeks have you tested positive for COVID 19 or are you currently being tested or monitored for COVID-19?	____	____
2. In the past two weeks have you had contact with anyone who has tested positive for COVID-19?	____	____
3. Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?	____	____

Patient Temperature: Date:

If the patient answers yes to any of these questions or their temperature is 100F or greater, they should not receive the vaccine at this time and follow up with their primary care provider.

Immunization Screening Questions	Yes	No
1. Are you sick today? i.e.: cold, fever, headache, or diarrhea.	____	____
2. Do you have allergies or reactions to any foods, medications, vaccines, or Latex?	____	____
3. Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting with vaccines? Have you ever had a physician or other healthcare provider caution you against receiving a vaccine?	____	____
4. Have you had a seizure, or other brain or other nervous system problem including Guillain Barre Syndrome?	____	____

Immunization Screening Questions (continued)	Yes	No
5. Do you take blood thinners?	____	____
6. Do you have a long-term health problem such as heart disease, lung disease, asthma, kidney disease, diabetes, anemia or other blood disorders?	____	____
7. Do you have an immune system disease such as cancer, leukemia, HIV/AIDs, rheumatoid arthritis, or ankylosing spondylitis?	____	____

8. Have you taken medicines such as Prednisone, other steroids, or chemotherapy which weaken your immune system, or received radiation therapy in the past 3 months? ____ ____
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? ____ ____
10. Are you pregnant or is there a chance you could become pregnant during the next month? ____ ____
11. Have you received any vaccinations or a TB skin test in the past 4 weeks? ____ ____

If you answered "yes" to any of these questions, please certify that you have been counseled by your health care provider and want to receive the Covid-19 vaccination.

Consent for services: I have been provided with the vaccine information sheet for the COVID19 vaccination that I am receiving. I have read the information provided about the vaccine, I have had the chance to ask questions that were answered to my satisfaction. I understand the risks and benefits of receiving this vaccine, and I fully and voluntarily assume full responsibility for any reaction that may result. I understand that I should remain in the vaccination area for up to 30 minutes after the vaccine to be monitored for any potential adverse reactions. I understand that if I experience severe side effects that I should contact my provider or call 911.
I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

Authorization to Request Payment: I do hereby authorize to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

Self-Attestation:
I understand that the vaccine supply is limited and, therefore, subject to prioritization in accordance with Centers for Disease Control and Washington State Department of Health directives. With that understanding, and with the understanding that I may have to supply proof of my eligibility, I hereby certify that I belong to one of the groups currently eligible for vaccination.

Emergency Use Authorization The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Signature of patient to receive vaccine (or parent, guardian, or authorized representative). **Date**

I HAVE READ THE FINANCIAL AGREEMENT. I UNDERSTAND AND AGREE TO THIS POLICY.

Signature of patient for acceptance of Financial Agreement (or parent, guardian, or authorized representative). **Date**

By my signature below I, acknowledge that I received or reviewed a copy of the Notice of Privacy Practices for WWMG.

Signature of patient for Notice of Privacy Practices (or parent, guardian, or authorized representative). **Date**

If signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.

Name of parent, guardian, or authorized representative Relationship Phone Number