COVID-19 Immunization Screening and Consent Form

Patient Information. Please Print Clearly.

Patient Full Name	Date of Birth	Gender Male/ Female
Address	Phone Number	Email
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Black or African American ☐ Pacific Islander ☐ Native American ☐ Other	Social Security Number (optional)	Driver's License
Occupation:	Mother's Maiden Name	County of Residence
Primary Language:	Marital Status	Ethnicity:

Parent/Legal Guardian Information (If patient is under the age of 18). Please Print Clearly.

Full Name	Date of Birth	Gender Male/ Female
Address(if different from above)	Phone Number	Email
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Black or African American ☐ Pacific Islander ☐ Native American ☐ Other	Relationship to Patient	Driver's License

Primary Insurance Carrier ID #: _____ Grp #: _____
Insurance Company: _____ Insurance Company Phone # _____
Insured's Name: _____ Relationship: _____ Insured's Date of Birth: _____
Secondary Insurance Carrier ID #: _____ Grp #: _____
Insurance Company: _____ Insurance Company Phone # _____
Insured's Name: _____ Relationship: _____ Insured's Date of Birth: _____

COVID-19 Screening Questionnaire. Please circle 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	NO
2. Have you tested positive for and/or been diagnosed with Covid-19 within the last 10 days?	YES	NO
3. Have you had a severe allergic reaction (e.g. needed epinephrine or hospital care) to a previous dose of vaccine or to any of the ingredients of this vaccine?	YES	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	NO
6. Do you carry an Epi-pen for emergency treatment of anaphylaxis and/or have allergies to reactions to any medications, foods, vaccines or latex? If so which_____	YES	NO
7. Are you immunocompromised or on a medication that affects your immune system?	YES	NO
8. Do you have a bleeding disorder or are you on a blood thinner. Blood-thinning medication?	YES	NO
9. For women, are you pregnant or is there a chance you could become pregnant?	YES	NO

10. For women, are you currently breastfeeding?	YES	NO
11. Are you under the age of 16?	YES	NO

Immunization Screening

Is this the patient's first or second dose of the COVID-19 vaccination? ☐ First Dose ☐ Second Dose
If this is your second dose, when was the date of your first dose?
If this is your second dose, which vaccine did you receive (Pfizer, Moderna, etc.)?
If this is your second dose, did you experience any allergic reaction to the first dose? If so which? _____

- 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 Tristate Community Healthcare or its agents to administer the COVID-19 vaccine.
- I understand that this product has not been approved or licensed by the FDA, but has been authorized for emergency use by the FDA, under an EUA to prevent Coronavirus Disease 2019 for use in individuals 18 years of age or 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.
- 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 that I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were/will be 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.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Tristate Community Healthcare, and their staff, agents, successors, divisions, affiliates, subsidiaries, 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 administrated of the vaccine listed above.
- I acknowledge that: (a) I understand the purposes/benefits of my personal immunization information that may be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize Tristate Community Healthcare or its agents to submit a claim to my insurance or Medicare Part B without supplemental coverage payment for me for 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 Tristate Community invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the Notice of Privacy Rights.

_____ _____

Patient/ Legal Guardian Signature Date

FOR ADMINISTRATIVE USE ONLY

Manufacturer Name	Dose	EUA Fact Sheet Date	Date of Vaccination	Lot #	Exp. Date	Route	MA Initials
☐ Pfizer (0.3cc) ☐ Moderna (0.5cc)	☐ First ☐ Second					☐ Left IM ☐ Right IM	

Consent for Treatment and Acknowledgments

To become a patient and receive treatment, we need your consent to provide care. We also need you to acknowledge that we have provided you with certain important information and documents. If you have any questions about any of this information, please do not hesitate to ask a member of our staff. By signing, you are indicating that you understand the information, have been given a chance to ask questions, and are giving your consent.

General Consent to Treat

I voluntarily agree to receive services from Tri-State Community HealthCare (TSCHC), and authorize the providers of TSCHC to provide such care, treatment, or services as are considered necessary and advisable for me. I understand that I should participate in the planning for my care and that I have a right to refuse interventions, treatment, care, services or medications at any time to the extent the laws allow. I understand that the care I will receive may include tests, injections, and other medications, etc. that are based on established medical criteria, but not free of risk.

Notice of Privacy Practices

I acknowledge that I have reviewed TSCHC's Notice of Privacy Practices and received TSCHC's Summary of Notice of Privacy Practice containing a description of the uses and disclosures of my health information. I understand that TSCHC has the right to change its Notice of Privacy Practices at times and that I can obtain a full copy of the Notice of Privacy Practices.

Patient's Bill of Rights and Responsibilities

I acknowledge that I have received TSCH Patient's Bill of Rights and Responsibilities and may request a copy at any time.

Release of Information for Billing and Consent to Reimburse

I know that TSCHC needs to send parts of my personal health information to organizations that help pay for my care, such as insurance payers or organizations that grant money to TSCHC. I allow TSCHC to release the relevant parts of my records so that my care can be paid for. If I do not feel comfortable with this, then I understand that I can request a higher level of privacy protection than is afforded to me under the Health Insurance Portability and Accountability Act (HIPAA).

Acknowledgement of Duty to Reimburse Tri-State Community HealthCare for Health Care Services

I understand that TSCHC offers a Sliding Fee Scale of discounted or free health care items and services to individuals who are deemed unable to pay based on their level of income. To become eligible for TSCHC's Sliding Fee Scale of discounted services, I will need to provide TSCHC staff with document establishing that I meet income eligibility requirements, which include proof of income and family size. If I do not provide the required documents to TSCHC, I am responsible for paying my fees for medical, behavioral health, or dental services received at TSCHC in full at the time of service.

Signature:	**Date:**
Printed Name: (If other than patient, print relationship)	**Date of Birth:**