Tri-State Health Services

Tri-State Memorial Hospital & Medical Campus

# COVID-19 VACCINE PATIENT ACKNOWLEDGMENT

## Patient Information

Patient Name _____ Age _____ Date of Birth ____/____/_____

Phone # _____ Phone Type _____ Email _____

Mailing Address _____ City _____ State _____ Zip _____

**Information collected below will help ensure we deliver equitable and patient-centered care.**

Gender ❑ Male ❑ Female ❑ Non-binary
❑ Unspecified/indeterminant

Ethnicity ❑ Hispanic or Latino
(Including Spanish, Mexican, Puerto Rican, Cuban, etc.)
❑ Not-Hispanic A person not of Spanish culture or origin

Race ❑ Black or African American ❑ White
❑ Asian ❑ American Indian or Alaska Native
❑ Hawaiian or Pacific Islander

**Which dose of the COVID-19 vaccine have you received?**
❑ Pfizer ❑ Moderna ❑ Janssen ❑ Other
Date of Series Completion ____/____/_____

**Which dose are you wanting to receive?**
❑ 1st Dose ❑ 2nd Dose ❑ Booster/Additional Dose

**Did you bring your vaccination record card or other documentation?** ❑ Yes ❑ No

Insurance card and driver's license copied?
❑ Yes ❑ No

## Screening Questions - Please circle your answer

| | | |
|---|---|---|
| Do you have a known history of a severe allergic reaction (e.g. anaphylaxis) to this vaccine or any components of the vaccine such as lipids, potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose? (Full list is available in the *Fact Sheet for Vaccine Recipients and Caregivers* or from your healthcare provider)<br>• Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures) | Yes | No |
| In the past two weeks have you tested positive for COVID-19? | Yes | No |
| Are you feeling sick today? | Yes | No |
| Have you received passive antibody therapy as part of COVID-19 treatment or for post-exposure prophylaxis? | Yes | No |
| Are you pregnant or breastfeeding? | Yes | No |
| Do you have a history of severe allergic reaction (e.g. anaphylaxis) to another vaccine or injectable medication? If yes, what vaccine or injectable medication? _____ | Yes | No |
| Are you immune compromised or on a medication that affects your immune system? | Yes | No |
| Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving a COVID-19 vaccine? | Yes | No |
| Do you have a bleeding disorder or are you on a blood thinner? | Yes | No |
| Do you have a history of Guillain-Barre syndrome? | Yes | No |
| Have you received dermal fillers in the last 3 months? | Yes | No |
| Do you have a history of myocarditis or pericarditis? | Yes | No |
| Have you been diagnosed with multi-system inflammatory disorder (MIS-C for children/MIS-A for adults) | Yes | No |

## Insurance Information

*Only complete this section if the insurance is under a different name (i.e. Spouse, Parent, Child).*

Guarantor Name _____ Relation to Patient_____

Guarantor Date of Birth ____/____/_____ Phone # _____ Phone Type _____

## Parental Consent (For Patients Under 18 Years Old)

❑ Parent or guardian accompanied patient and approves vaccine administration

❑ Verbal given over the phone for vaccine administration

Parent or Gaurdian Who Gave Consent _____

Witness #1 _____ Witness #2 _____

Tri-State Health Services

Tri-State Memorial Hospital & Medical Campus

# COVID-19 VACCINE PATIENT ACKNOWLEDGMENT

If you are not insured and you do not want to pay for administration of the vaccine yourself, you must provide the information below.

I do not have any insurance, including but not limited to Medicare, Medicaid, or any other private or government-funded health benefit plan. In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients please provide **(a) a valid Social Security number, or (b) state identification number and state of issuance, or (c) a driver's license number and the state of issuance.**

Acknowledgements:

- I made the choice to get the COVID-19 vaccine on my own and freely. I know I have the option to refuse the vaccine. I ask that the vaccine be given to me, or to the person named above for whom I can make this request. I was given the (Fact Sheet for Vaccine Recipients and Caregivers) for this vaccine. The fact sheet has information about side effects and adverse reactions. I read or had read to me the information provided about the COVID-19 vaccine.
- I know the Food and Drug Administration (FDA) has authorized the emergency use of this vaccine. I know it is not a fully licensed FDA vaccine. I had the chance to ask questions that were answered to my satisfaction. I now know about the vaccine, alternatives, benefits, and risks, to the extent they are known and unknown at this time.
- I know that I must stay in the vaccine area or an area told to me by my health care provider after I receive my immunization so I am near my health care provider if I have any adverse reactions. If I have a history of severe allergic reaction, (e.g. anaphylaxis), I must stay for 30 minutes. If I do not have a history of severe allergic reaction, I may stay for 15 minutes.
- I know that if I have a severe allergic reaction, including difficulty breathing, swelling of my face and/or throat, a fast heartbeat, a bad rash all over my body, or dizziness and weakness I should call 9-1-1 or go to the nearest hospital. I know I can call my healthcare provider if I have any side effects that bother me or do not go away.
- I was asked to join the V-SAFE program. The program does health checks on the people who get the COVID-19 vaccine. I know I should report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 or https://vaers.hhs.gov/reportevent.html.

***Authorization to Request Payment:*** *I authorize the organization providing my vaccine 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.*

***Disclosure of Records:*** *I understand the organization providing my vaccine may be required to or may voluntarily disclose my vaccine-related health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also understand the organization providing my vaccine will use and disclose my health information as described in its Notice of Privacy Practices which I may receive upon request or find on its website.*

**I have reviewed the screening and exclusion questions. I have read the consent and disclosure of records statement and agree to all the above. If you are signing on behalf of the patient, you are stating that you are authorized to make the required decisions on behalf of the patient.**

**1st Dose**

_____ Printed Name of Patient, Guardian, or Authorized Representative

_____ Signature of Patient, Guardian, or Authorized Representative

Date _____/_____/_____

**2nd Dose**

_____ Printed Name of Patient, Guardian, or Authorized Representative

_____ Signature of Patient, Guardian, or Authorized Representative

Date _____/_____/_____

**Booster/ Addtiotnal Dose**

_____ Printed Name of Patient, Guardian, or Authorized Representative

_____ Signature of Patient, Guardian, or Authorized Representative

Date _____/_____/_____

## For Office Use Only

**1st Dose**

Date ____/____/_____ Time of admin _____

Site of injection ❑ Right deltoid ❑ Left deltoid

❑ Vaccine Brand _____

Lot #_____ Exp. Date ____/____/_____

Administered by _____

Documented in IIS ❑ Yes ❑ No

**2nd Dose**

Date ____/____/_____ Time of admin _____

Site of injection ❑ Right deltoid ❑ Left deltoid

❑ Vaccine Brand _____

Lot #_____ Exp. Date ____/____/_____

Administered by _____

Documented in IIS ❑ Yes ❑ No

**Booster/Additional Dose**

Date ____/____/_____ Time of admin _____

Site of injection ❑ Right deltoid ❑ Left deltoid

❑ Vaccine Brand _____

Lot #_____ Exp. Date ____/____/_____

Administered by _____

Documented in IIS ❑ Yes ❑ No

IIS# _____