COVID Vaccine Intake Consent Form

Elite MEDICAL

Form 1 of 2 to be completed

Clinic Information

Clinic ID 54ECMS Clinic Name City of Visalia & UnitedAg Health & Wellness Telephone 559-713-0422

Address 315 S. Johnson St. City Visalia State CA Zip 93291

Patient Information

Last Name First Name Date of Birth Gender

Address City State Zip

Occupation Phone Number Email Address

Primary Care Provider (PCP) Name PCP Phone Number PCP Fax Number

PCP Address City State Zip

Are you a **resident** ◯ of a Long Term Care facility or an **employee** ◯ ?

Is this the patient's first ◯ or second ◯ dose of the COVID-19 vaccination?

Insurance Information: (For onsite clinics, please ensure a copy of the patient's insurance card(s) was collected)

*** INDICATES REQUIRED FIELDS**

Prescription Insurance: ◯Yes ◯No

*Are you the primary cardholder? *If no, include the primary cardholder's DOB

*Prescription Benefit Plan Name *Cardholder ID # *RX Group ID *BIN *PCN

Medicare Fields:

◯Yes ◯No

*Is the Patient age 65 or older or Medicare Eligible?

*Medicare Part A/B ID Number (MBI) Note: MBI is required for all patients age 65 and older, or Medicare eligible. Refer to your Medicare Red, White, and Blue card

Medical Insurance:

*Medical Insurance Provider *Cardholder ID # *Group ID *Payer ID

◯Yes ◯No

*Is the patient the primary cardholder? *If no, include primary cardholder's DOB

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

I 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 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.

*Social Security Number or State Identification Number & State or Driver's License Number & State

Potential Contraindications	YES	NO	DON'T KNOW
1. Are you feeling sick today?	◯	◯	◯
2. Have you ever received a dose of COVID-19 vaccine? **If yes**, which vaccine product? Pfizer Moderna Another product: _____	◯	◯	◯
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) in the past? Example: a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?	◯	◯	◯
Was the severe allergic reaction after receiving a COVID-19 vaccine?	◯	◯	◯
Was the severe allergic reaction after receiving another vaccine or injectable medication?	◯	◯	◯
Was the severe allergic reaction related to receiving Polyethylene Glycol or products containing Polyethylene Glycol?	◯	◯	◯
Was the severe allergic reaction related to receiving Polysorbate or products containing Polysorbate?	◯	◯	◯
Do you have any other drug related allergies? if yes, please list:	◯	◯	◯

Form 2 of 2 to be completed

Last Name | First Name | Date of Birth

Potential Contraindications continued

	YES	NO	DON'T KNOW
4. Have you received any vaccines in the past 14 days?	○	○	○
5. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?	○	○	○

Potential Considerations

	YES	NO	DON'T KNOW
6. Do you have a bleeding disorder or are you taking a blood thinner?	○	○	○
7. For women, are you currently pregnant or breastfeeding?	○	○	○

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call pharmacy, contact doctor, 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 Elite Corporate Medical Services, Inc. ("ECMS") 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 that ECMS may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at ECMS (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that ECMS will use and disclose my health information as set forth in the Privacy Practices. State of California only: I agree to have CAIR share my immunization data with Health Care Providers, agencies or schools. Vaccine Clinics: If I am receiving a vaccine through a vaccine clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator.

X

Signature of patient to receive vaccine (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 | Phone Number | Relationship

Vaccine Administration Information **for Immunizer/Pharmacist use only**

Administration Date	Vaccine	VIS Date	Manufacturer	Volume (mL)
	Moderna		Moderna, US Inc.	0.5

Lot #	Exp. Date	Route	Site
			○ L ○ R

Patient Temperature *(If patients body temperature is 100.4 degrees F or greater, inform them they should not recieve the vaccine at this time.)*

Administering Immunizer Name & Title | Administering Immunizer Signature

To be filled out by immunizer, as required for state immunization registry reporting. Only for states listed.

MS: Check all fields for patients 18 years of age and younger

OK: Check Race and Ethnicity for all patients. Select Next of Kin for patients 18 years of age and younger.

Race: ○ **1** - American Indian or Alaska Native ○ **2** - Asian ○ **3** - Native Hawaiian/Other Pacific Islander ○ **4** - Black or African American ○ **5** - White ○ **6** - Other Race

Ethnicity: ○ **1** - Hispanic ○ **2** - Not Hispanic or Latino ○ **3** - Unknown

Next of Kin (18 or younger)

Name | Phone Number | Relationship

Address

State of NJ only

Prescriber Name | Prescriber Address

For CA, MA, MT, NJ, NM, NY, TX (For CA, this indicator means the registry will not share with Universities, Schools or other agencies) **Registry Sharing Indicator:** ○ Yes ○ No