COVID Vaccine Intake Consent

Elite MEDICAL

Form 1 of 2 to be completed

Patient Information

First Name:		Ethnicity:	
Last Name:		Race:	
DOB:		Gender:	
Address:		City:	
State:		Zip:	
Company:		Phone Number:	
Email:			

Medical Insurance:

Insurance Plan: **Insurance ID:**

Is the patient the primary cardholder? ◯ Yes ◯ No

If no, include primary card holder's DOB:

*** If uninsured, please provided your Social Security Number & CA or Mexico ID**

* Social Security Number: * ID Number & State:

*** IS THIS YOUR ☐ FIRST, ☐ SECOND OR ☐ THIRD (booster) DOSE OF THE COVID-19 VACCINE?**

- **If this is your second or third dose, what were the dates of your previous doses?**

1st: _____ **2nd:** _____

- **Which vaccine did you receive?**

☐ **Pfizer** ☐ **Moderna** ☐ **Janssen (Johnson & Johnson)** ☐ **Other**

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?	◯	◯	◯

Potential Contraindications (continued)

	YES	NO	DON'T KNOW
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:	◯	◯	◯
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

Parent/Guardian Signature **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.

OFFICE USE ONLY!

Vaccine Administration Information

Administration Date	Vaccine	VIS Date	Manufacturer	Volume (mL)

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 receive the vaccine at this time)*

X

Administering Immunizer Name & Title **Administering Immunizer Signature**

Clinic Name: