**COVID-19 Vaccine Consent Form**

| PATIENT INFORMATION | | | | |
|---|---|---|---|---|
| Patient's **LEGAL** Last Name: | Patient's **LEGAL** First Name: | Phone Number: | Age: | Birthdate: |
| Street Address: | City: | County: | State: | Zip Code: |
| Assigned sex at birth:<br>☐ Female ☐ Male<br>Are you Hispanic or Latino<br>☐ Yes ☐ No | Race: (Select one or more)<br>☐ AS-Asian/Pacific Islander/Other ☐ BL-Black or African American ☐ CH-Chinese<br>☐ CA-Caucasian (White)/Mexican/Puerto Rican ☐ FI-Filipino ☐ HA-Hawaiian<br>☐ IN-Native American/Alaska Native ☐ JA-Japanese<br>☐ NW-Other Non-White ☐ UN-Unknown | | | |
| Insurance Company or Medicare: | ID#: | Group# (Insurance Only): | Primary Physician: | |

| VACCINATION SCREENING QUESTIONNAIRE | |
|---|---|
| 1. Are you currently sick or experiencing a high fever? | ☐ Yes ☐ No |
| 2. Have you had a life threatening allergic reaction to any vaccine or other injection in the past? | ☐ Yes ☐ No |
| 3. Do you have any allergies to Benadryl, solumedrol, epinephrine, polysorbate, Polyethylene glycol, or prior COVID-19 vaccine? Please list: | ☐ Yes ☐ No |
| 4. Have you received any other vaccine in the past 14 days? List: | ☐ Yes ☐ No |
| 5. Have you been diagnosed with COVID-19 in the past 90 days? If yes, did you receive passive antibody therapy or plasma as part of their treatment? ☐ Yes ☐ No | ☐ Yes ☐ No |
| 6. In the past 3 months, have you taken medications that weaken their immune system, such as cortisone, Prednisone, other steroids, or anti-cancer drugs, or had radiation treatments? | ☐ Yes ☐ No |
| 7. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? | ☐ Yes ☐ No |
| 8. Do you have a health problem with lung, heart, kidney, diabetes, asthma, thrombosis-thrombocytopenia syndrome (TTS), a blood or bleeding disorder, or on a blood thinner? Circle any medical condition that applies to you. | ☐ Yes ☐ No |
| 9. Are you breastfeeding? | ☐ Yes ☐ No ☐ N/A |
| 10. Are you pregnant or have a chance of becoming pregnant within the next month? | ☐ Yes ☐ No ☐ N/A |
| 11. Have you previously received a COVID-19 vaccine? ☐ Yes ☐ No<br>If yes, please select: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ☐ Other: Date: | |
| 12. Have you had an adverse reaction to any COVID-19 vaccine? ☐ Yes ☐ No ☐ N/A | |
| 13. If you answered yes to #12, did the adverse reaction require emergency medical attention? | ☐ Yes ☐ No ☐ N/A |

Please read and check each of the following statements that apply to you then sign.

☐ I have been offered a copy of the Vaccine Fact Sheet EUA for the COVID-19 vaccine checked below, whether accepted or not. I have read or had explained to me the information in the Fact Sheet, including the possible adverse reactions, the components of the vaccine, the possible risks, and what to do after the vaccination.

☐ I ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I consent to the inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the above named person.

☐ I attest that I have sufficient risk of infection and/or complications that I qualify for the administered vaccine.

☐ *I understand the importance of remaining in the clinic for 15 minutes after I/person named above receive(s) this vaccine. I understand that there is an increased risk of allergic reactions and syncopal episodes within the first 15 minutes after a vaccination, and if I/person named above choose to leave the facility, I assume responsibility for this risk.*

☐ If the person named above is a minor, I do hereby solemnly swear that I have legal custody of the aforementioned minor. I grant authorization and consent for Saline County Vaccination Collaboration to administer the COVID-19 vaccine to the above named minor and provide medical evaluation and treatment throughout the vaccine process, including administration of medications and calling EMS for transport to the nearest emergency department.

**Signature of Patient or Parent/Guardian:**_____ **Date:** _____

**Staff use only:**

| *VACCINE* | *DOSE* | *EXT* | *SITE* | *ROUTE* | *MANUFACTURER LOT #* | *EXP DATE* |
|---|---|---|---|---|---|---|
| **Moderna** | **0.5 ml. 1 2 3**<br>**0.25 ml. B** | **RT LT** | **Deltoid**<br>**Vastus Lat** | **IM** | **Moderna** | |
| **Pfizer** | **0.3 ml.**<br>**1 2 3 B** | **RT LT** | **Deltoid**<br>**Vastus Lat** | **IM** | **Pfizer** | |
| **J & J** | **0.5 ml.**<br>**1 B** | **RT LT** | **Deltoid**<br>**Vastus Lat** | **IM** | **Janssen** | |

**Signature and Title of Vaccine Administrator** _____ **Date Given** _____

# SALINA FAMILY HEALTHCARE CENTER

Chart #: _____

## NEW & ANNUAL PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

| Legal Name: | DOB: |
|---|---|

**Assignment of Benefits and Authorization to Release Medical Information:**
I request that payment of authorized benefits from Medicare, Medicaid, and/or any insurance carrier applicable, be made to me, or on my behalf, to Salina Family Healthcare Center, for any services, including, but not limited to, telemedicine and/or teledentistry, furnished to me and/or my dependent family members by my provider. I authorize any holder of medical/dental information about me and/or my family members to release it to the Division of Family Services, the Centers for Medicare and Medicaid Services (CMS), applicable insurer(s), and/or agent of these companies, and/or the listed responsible person(s), and information needed to determine these benefits or the benefits for other related services.

**Immunization Consent:**
I give consent for my child to receive all immunizations recommended by the Center for Disease Control. I understand that this clinic follows the Center for Disease Control's guidelines for schedules, doses, and particular vaccines in administering these immunizations. I understand that this consent is applicable if I am filling out this form on behalf of a minor child.

**Financial Account Policy:**
By my signature below, I am agreeing to the Financial Account policies set forth by Salina Family Healthcare Center. A detailed description of the Financial Account Policy is available for all patients, upon request.

**Disclosure of Insurance Coverage:**
I have also disclosed all insurance coverage in effect at the time services were provided to me. I understand that failure to inform Salina Family Healthcare Center of any third party insurance coverage will be considered fraud and I understand that the clinic will prosecute to the fullest extent of the law.

**Acknowledgement of Services:**
By signing below, I acknowledge that Salina Family Healthcare Center provides an integrated care model where behavioral health screenings and consults will be part of the patient-centered care provided.

**Patient and Center Rights and Responsibilities:**
I acknowledge that I have received a copy of Salina Family Healthcare Center's Patient and Center Rights and Responsibilities form. We ask you acknowledge your receipt of this document by signing below. You should keep a copy of the Center's Patient and Center Rights and Responsibilities; however, if you wish to receive another copy you may request a copy at any time. The most current copy of Center's Patient and Center
Rights and Responsibilities will be posted in our office. I acknowledge that I received a copy of Center's Patient and Center Rights and Responsibilities effective May 19, 2016.

**Notice of Privacy Practices**
Maintaining privacy of your health information is very important to us. You have been offered our Notice of Privacy Practices. We ask you acknowledge your receipt of this Notice by signing below. You should keep a copy of the Notice; however, if you wish to receive another copy you may request a copy at any time. The most current copy of this Notice will be posted in our office as well as the website. I acknowledge that I was offered a copy of Center's Notice of Privacy Practices effective October 28, 2020.

**Televideo visits**
I consent to telemedicine visits, including medical, behavioral health, dental, pharmacy, and nursing visits. I agree to use the video-conferencing platform for virtual sessions. *All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. All existing confidentiality protections under federal and Kansas state law apply to information disclosed during this telemedicine consultation/appointment. You may withhold or withdraw consent to the telemedicine consultation or appointment at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. Video, audio, and/or photo recordings may be taken during the consultation, appointment, or service.

**Patient/Legal Guardian Signature:** **Today's Date:**

For Office Use Only

Form Processed by: _____