First District Health Unit COVID-19 Vaccine Consent Form

PLEASE PRINT. Use full, legal name.

FIRST NAME_________________________ **M.I.** _____ **LAST NAME**_________________________

DATE OF BIRTH ________________ **AGE**______ **M**____ **F**____ **PHONE**_________________________

ADDRESS_________________________ **CITY**________________ **STATE**_____ **ZIP**___________

RACE Circle all that apply: White, American Indian, African American, Alaska Native, Asian, Hispanic/Latino, Pacific Islander, Other, Unknown

Answer health questions for person getting COVID-19 vaccination

Y____N____ Are you feeling sick today?

Y____N____ Have you ever received a dose of COVID-19 vaccine?

Y____N____ Have you ever had a **severe** allergic reaction (anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?

- Y____N____ was the severe allergic reaction after receiving a COVID-19 vaccine?
- Y____N____ was the severe allergic reaction after receiving another vaccine or another injectable medication?

Y____N____ Have you received monoclonal antibodies or convalescent plasma for COVID-19 treatment in past 90 days?

Y____N____ Have you received any vaccines in the past 14 days?

Y____N____ Have you had a positive test for COVID-19 or has a doctor ever told you that you have COVID-19?

Y ___ N____ Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?

Y____N____ Do you have a bleeding disorder or are on a blood thinner?

Y____N____ Are you pregnant or breastfeeding?

☐ **MEDICAID OR MEDICARE NUMBER:** ___________________________________

☐ **INSURANCE COMPANY**: _________________________ Payer ID / EDI #:____________back of card

Policy Holder: Name (First MI Last): _________________________ Date of Birth: ____________

Gender: Male / Female Relationship to client: ____________________ Group #______________

Policy Holder ID #*:____________________ Client ID # (if different): ____________________

Tricare** use 11 digit **Benefits Number** on ***back of card: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

I have viewed the Factsheet provided. I have read the information about the vaccine. I had an opportunity to ask questions and believe that I understand the benefits and risks of the vaccine. **I consent to the administration of the vaccine(s) listed to be given to the person named above & am authorized to give consent.** FDHU **Notice of Privacy Practices** is available online or by request. I assign and **authorize any third-party payer/insurer** to make direct payment to FDHU. I will not be responsible for charges not covered by 3rd party payer. I authorize the release of information necessary to process this claim. Info will be shared with the ND Immunization Info System.

SIGNATURE OF CLIENT OR PERSON AUTHORIZED TO CONSENT ON THE CLIENT'S BEHALF TO RECEIVE VACCINATION:

X____ **DATE:**________________

FOR FDHU STAFF USE ONLY				
Lot #	Site: LA RA	☐ 1st Dose ☐ 2nd Dose	Vaccine Administrator Initials	Date
SAVE PAPER CONSENT	Demo	Note done/sent	ESB ✓	Revised 12/28/2020