COVID VACCINE Consent & Authorization of Benefits

CLEARLY print name _____ **Date of Birth** _____ **Age** ____

Address _____ **CITY** _____ **ZIP** _____

Sex MALE / FEMALE **Home phone** _____ **Cell phone** _____

Family Doctor/ Facility _____

READ THE VACCINATION INFORMATION BEFORE COMPLETING THIS FORM

I want to receive the COVID-19 Vaccination and certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to Orange City Area Health System and the licensed healthcare professional to administer the vaccine. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated the vaccine and have received, read and/or had explained to me the EUA Fact Sheet. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. **Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 – 30 minutes after administration.** I hereby release and hold harmless the provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed below. I hereby do consent to the applicable reporting of vaccination information to governmental agencies as required, including the state immunization registry.

THIS WILL BE PROCESSED THROUGH YOUR INSURANCE CARRIER

Insured Name _____ **Date of Birth** _____

Employer _____ **Policy#** _____ **Group #** _____

Insurance Carrier _____ **Insurance Phone #** _____

Insurance Claim Address _____

**** MUST ATTACH A COPY OF INSURANCE CARD ****

Screening Questions:	**Yes**	**No**
Are you feeling sick today?		
Have you ever received a dose of a COVID-19 vaccine? If yes, which one? _____ When? _____		
Have you had any other vaccines in the last 14 days?		
Have you received COVID antibody therapy in the last 90 days (bamlanivimab, bamlanivimab + etesevimab, casiribmimab + imdevimab, convalescent plasma)?		
Have you ever had a severe allergic reaction that required epinephrine (EpiPen) or caused you to go to the hospital (ex. Anaphylaxis or hives/swelling/respiratory distress within 4 hours)?		
Have you ever had a severe allergic reaction (anaphylaxis or hives/swelling/respiratory distress within 4 hours) after receiving another vaccine or another injectable medication?		
Are you allergic to polysorbate?		
Are you allergic to polyethylene glycol (PEG, Miralax)?		
Have you had a severe or immediate reaction to a previous dose of COVID vaccine or its components?		
Women: Are you pregnant or considering becoming pregnant in the next month?		

I consent the release of my medical information for payment purposes to health insurers or third party payers. I hereby authorize payment directly to the provider for insurance benefits otherwise payable to me, but not to exceed the balance due of the provider's regular charge for this vaccination.

I have read the above statement and understand the benefits and risks. I request the vaccine be given to me, or to the person named above of whom I am the parent or guardian.

Signature_____**Date**_____

Vaccine	**NDC**	**Manufacturer**	**EXP date**	**Dosage**	❒ **Dose 1**	**LT Deltoid**	**EUA Fact Sheet Date**
					❒ **Dose 2**	**RT Deltoid**	

DATE OF VACCINATION:

Orange City Area Health System