Regional Health Services of Howard County
Howard County Community Health

☐ **1st Dose**
☐ **2nd Dose**
☐ **Additional Dose**
☐ **Pediatric Pfizer**
5 – 11 yrs old
6m - 4 yrs old

COVID-19 VACCINATION ASSESSMENT, RELEASE AND CONSENT FORM

Vaccine Recipient Information

Name: _____ Birth Date: _____
First Middle Initial Last

Gender: ☐ Male ☐ Female ☐ Nonbinary

Phone : _____ Email: _____

Address: _____
Street City State Zip

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Vaccine Eligibility Assessment and Screening Questions:

	YES	NO	DON'T KNOW
1. Are you sick today?	☐	☐	
2. Do you have allergies to polysorbate?	☐	☐	☐
3. Do you have any allergies or anaphylactic reaction requiring intervention?	☐	☐	☐
4. Have you ever had Guillain Barre Syndrome?	☐	☐	☐
5. If you were diagnosed with COVID in the past 90 days, did you receive an infusion treatment?	☐	☐	☐
6. Have you previously received a COVID-19 vaccine?			
If YES, indicate date the COVID-19 vaccine received: _____	☐	☐	☐
(circle one) Pfizer, Moderna, Astra Zeneca, Johnson & Johnson _____			

Acknowledgement:

I understand I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. If I have had a previous severe reaction to a vaccine, I will be monitored for 30 minutes. I understand if I experience any side effects after leaving the vaccination area, I should call my doctor, or if the side effects are severe, I should call 911.

Insurance:

Please provider medical insurance information for the vaccine recipient.

Insurance Name: _____ Card Holder Name: _____

Group or Policy Number: _____

☐ **If uninsured, you must check the box to attest that the following information is true and accurate:** 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 please provide either (a) valid Social Security number, (b) state identification number and state of issuance, OR (c) a driver's license number and state of issuance:

Identification Type: _____ Number: _____ State of Issuance: _____

Authorization for Payment:

I authorize release of my personal, billing and medical information to third party payers, insurance companies or review agencies for use in connection with payment, including eligibility for payment, regulatory or accreditation compliance or as is required for provider to receive payment or reimbursement for care. I authorize and irrevocably assign to the administrator of the vaccine payment of any benefits payable to me/amounts payable for the vaccine I receive.

Disclosure of Records:
I understand Regional Health Services of Howard County and its affiliates 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 by RHSHC and its affiliates, my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or states/federal registries, for purposes of treatment, payment or other health care operations.

Consent:
I was provided the Fact Sheet for Recipients for the COVID-19 vaccine I am receiving. I have read and/or have had explained to me the information provided about the vaccine in the Emergency Use Authorization (EUA) or Vaccine Information Statement. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and voluntarily ask that the vaccine be administered to me or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problem resulting in this vaccination.

Patient signature_____ Date: _____

Guardian or Patient Representative Signature: _____

Relationship to patient (if applicable) _____ Date: _____

For office use only **COVID-19 Vaccine Administration**

☒ COVID-19 Vaccine ☒COVID-19 Vaccine EUA Fact Sheet for Recipients provided.

Vaccine Manufacturer & Lot Number Information
(circle vaccine name, write lot number, indicate which arm) ☐ **R Deltoid** ☐ **L Deltoid**

Moderna: _____ Full Dose Pfizer: _____ Adult Dose 30mcg/0.3mL Janssen (J&J)
_____ Half Dose _____ Pediatric Dose 10mcg/0.2mL (5 - 11 yrs old
_____ Pediatric Dose 3mcg/0.2mL (6m-4yrs old)

Lot Number: _____

Date: _____ Time: _____

Administered by: _____
Signature

Patient Known Vaccine History

1st: _____ Brand: _____
2nd: _____ Brand: _____
3rd/Booster: _____ Brand: _____

Notes: