COVID Vaccine Intake Consent Form

☐ First Dose ☐ Second Dose ☐ HRSA

Patient Information

Last Name	**First Name**	**Date of Birth**	**Age**
			☐ M ☐ F ☐ Other
Mother's Last Name	Mother's First Name		**Gender**

Address:

Street	Apt. #	City	Zip

Phone # ( ) ( ) ( )

Home	Work	Cellular

Emergency Contact: ______________________________

Name	Relationship	Telephone #

Demographics – Must check at least 1 box per section

Race:
- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian / Pacific Islander
- ☐ White
- ☐ Other/Race

Ethnicity:
- ☐ Hispanic / Latino
- ☐ Non-Hispanic / Latino

- ☐ Migratory/Seasonal Agricultural Workers
- ☐ Individuals Experiencing Homelessness
- ☐ Residents of Public Housing
- ☐ Individuals with Limited English Proficiency
- ☐ Not Applicable

Insurance Information:

*Patient Disclosure: The vaccine is free. Your insurance will be charged for the cost of administering your vaccine and supplies.
You are personally NOT responsible for any costs.

Insurance Type	Insurance Company Name	Member ID Number	Group Number
Policy Holder Last Name	Policy Holder First Name	Policy Holder Date of Birth	
Policy Holder Relation to Patient			

Your Vehicle Information on day of Vaccine appointment

Color	Make	Model

Number #: ______________

COVID Vaccine Intake Consent Form

☐ First Dose ☐ Second Dose ☐ HRSA

Check all that apply.

- ☐ I currently reside in Alameda County
- ☐ I currently work in Alameda County
- ☐ I currently reside in Santa Clara County
- ☐ I currently work in Santa Clara County

Please indicate the city that you live and/ or work in:____

SECOND DOSE NOTIFICATION: I acknowledge that I may need to schedule a second dose of vaccine. I consent to receiving email or text messages about ongoing care and with reminders regarding my COVID-19 vaccine appointment if I have not yet received my second vaccine dose. I understand that such messages will not be sent securely.

CONSENT FOR VACCINATION

I have been provided with the COVID-19 Vaccine Fact Sheet for Recipients and Caregivers. I have read the information provided about the vaccine I am or my child/children is/are about to receive and have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccination. I understand that I should remain in the post-vaccine observation area for a minimum of 15 minutes to be monitored for any potential adverse events.

DISCLOSURE OF RECORDS

I understand that BACH may be required to disclose my health information to state or federal registries for purposes of treatment or other needs such as public health purposes, surveillance tracking and safety monitoring. The following individually identifiable health information may be disclosed: vaccination type and identification numbers, date of vaccination, including all doses and subsequent follow-up information. I hereby consent to BACH staff to access my electronic medical record for the purpose of documenting my vaccination encounters.

X ____

Signature of patient to receive vaccine (or parent, guardian or authorized representative) 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.

____

Name of patient to receive vaccine

____

Name of parent, guardian, or authorized representative Phone Number Relationship

Appointment Time: ______________Number #: ______________

COVID Vaccine Intake Consent Form

☐ First Dose ☐ Second Dose ☐ HRSA

Patient Name:____DOB: _________________________

COVID Vaccination Screening Questions	YES	NO	DON'T KNOW
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19?	☐	☐	☐
If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ other: ______________________________			
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 there severe allergic reaction after receiving a COVID-19 vaccine?	☐	☐	☐
– Was there severe allergic reaction after receiving another vaccine or injectable medication?	☐	☐	☐
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?	☐	☐	☐
6. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
7. Do you have a weakened immune system or currently take medications that can diminish your immune response? (i.e., HIV medications, steroids, anticancer drugs or radiation treatment, etc.)	☐	☐	☐
8. For women, are you currently breastfeeding or pregnant?	☐	☐	☐

____

Signature **Date**

Info Reviewed and OK to give Covid Vaccine: ____

Staff

☐ LD ☐ RD Time: ______________________________ Initials:_________________________

V5 – 05-10-2021
BACH – Covid-19 Vaccination Packet
S:\COVID-19\Forms\Registration Form