COVID-19 VACCINE INFORMATION & CONSENT FORM

COVID-19 Immunization Acknowledgments

I have been given a copy of and have read (or have had explained to me) the information in the Emergency Use Authorization Fact Sheet for Vaccine Recipients and Caregivers or the Vaccine Information Statement for the vaccine I am receiving, and that it contains information about potential side effects and adverse reactions. I have had a chance to ask questions about the Fact Sheet/VIS, the vaccine itself and this form, which were all answered to my satisfaction.

I understand and accept that the vaccine I am receiving has been authorized by the U.S. Food and Drug Administration (FDA) for emergency use, pursuant to an Emergency Use Authorization and not the normal FDA approval process. I understand the benefits, alternatives and risks of receiving the vaccine to the extent they are known and unknown at this time. I understand that the vaccine I am receiving the vaccine to the extent they are known and unknown at this time. I understand that the vaccine I am receiving requires two doses of the same vaccine and that, as with all vaccines, there is no guarantee that I will become immune to COVID-19 or that I will not experience side effects. I have decided to receive the COVID-19 vaccine voluntarily and freely. I understand that I have the option to refuse the vaccine. I assume full responsibility for any result or reaction, and I hereby request that the vaccine be given to me or to the person named above for whom I am legally authorized to make this request.

I understand that I must remain in the vaccine administration area identified by my health care provider for at least 15 minutes, or as directed, after vaccination to be monitored for any adverse reaction. I understand that if I experience any suspected adverse reaction or side effects at any time, including but not limited to difficulty breathing, swelling of my face and/or throat, a fast heartbeat, rash all over my body or dizziness and weakness, I should contact my health care provider immediately.

x_____ _____

Signature of Patient/Authorized Representative **Date**

_____

Printed Name of Authorized Representative

Authorization to Request Payment: I authorize Quality of Life Health Services to release my health information and request payment. I certify that the information I have provided in applying for payment under Medicare, Medicaid or other insurance or government funded health benefit program is true and correct. I request that payment of authorized benefits be made on my behalf, and I hereby authorize release of all records necessary to act on this request.

Disclosure of Records: I understand and agree that Quality of Life Health Services may be required to or may voluntarily disclose my health information to my primary care physician, my insurance plan, other health systems or hospitals, and state and federal agencies or registries, for purposes of treatment, payment, or healthcare operations or for other purposes authorized or required by law. I understand that Quality of Life Health Services will use and disclose my health information according to its Notice of Privacy Practices, which I have received, or I may obtain at any time upon my request.

Authorization to Disclose to Quality of Life Health Services Employee Health (for QOLHS Employees Only): I authorize this vaccine acknowledgement and administration record to be disclosed to and used by Quality of Life Health Services Employee Health for occupational health/employment purposes, and I authorize Quality of Life Health Services to maintain my vaccine records in both my electronic health record (i.e. Epic) and my employee health record to the extent required or permitted by law.

x_____ _____

Signature of Patient/Authorized Representative **Date**

_____

Printed Name of Authorized Representative

Quality of Life
HEALTH SERVICES INC.

COVID-19 VACCINE INFORMATION & CONSENT FORM

EXCLUSION QUESTIONS

If patient answers "YES" to either of these questions or patient's temperature is 100.4° F or greater, patient should not receive the COVID-19 vaccine at this time. Instruct the patient to contact their primary care provider for next steps.

Are you under the age of 18 years? (Circle one)	Yes	No	Don't Know

VACCINE SCREENING QUESTIONS

If the patient answers "YES" to any of these questions, provide patient counseling or instruct the patient to consult with their caregiver prior to receiving the vaccine.

In the past 14 days have you tested positive for COVID-19?	Yes	No	Don't Know
In the past 14 days have you had exposure to a person who tested positive for COVID-19 at a distance of six feet or less for a period of 15 or more minutes without wearing appropriate personal protective equipment (e.g. masks)?	Yes	No	Don't Know
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?	Yes	No	Don't Know
In the past 90 days have you received passive antibody therapy as part of COVID-19 treatment?	Yes	No	Don't Know
In the past 14 days have you had any other vaccines?	Yes	No	Don't Know
Are you pregnant, breastfeeding or lactating, or do you plan to become pregnant?	Yes	No	Don't Know
Are you immune compromised or on any medicine that affects your immune system?	Yes	No	Don't Know
Do you have a bleeding disorder or are you on a blood thinner?	Yes	No	Don't Know
Do you have a history or sever allergic reaction (e.g. anaphylaxis) to another vaccine or injectable medication? If yes, what vaccine or injectable medication? _____	Yes	No	Don't Know
Have you ever had a serious reaction after receiving a vaccination?	Yes	No	Don't Know
Have you received a transfusion of blood or blood products during the past year?	Yes	No	Don't Know
Do you have any long-term health problems, heart, lung, kidney, or metabolic disease (e.g. diabetes), asthma, blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak?	Yes	No	Don't Know
Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes	No	Don't Know
Have you had a seizure, brain, or other nervous system problem?	Yes	No	Don't Know

CONSENT

CONSENT TO TREAT: I request and give consent to my provider to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my provider for my health and wellbeing. I acknowledge that no representations, warranties, or guarantees as to the results or cures have been made to me or relied upon by me.

Signature: _____ Date: _____
(Patient, parent or guardian)

Witness: _____ Date: _____

Signature of Patient/Guardian: _____Date: _____

(FOR CLINIC USE ONLY)

Date Vaccine and VIS Given	Type and Date of VIS or EUA Fact Sheet	Clinical Site:	County Code:	NCES #:

Vaccine Given: ☐ Pfizer 1st dose ☐ Pfizer 2nd dose ☐ Moderna 1st dose ☐ Moderna 2nd dose ☐ Johnson & Johnson 1st dose

Site Location:	Manufacturer:	Lot Number:	NDC#:	Site of Injection: LA RA	Route IM

Designated Employee Signature:	**Date:**

Quality of Life
HEALTH SERVICES INC.

P.O. Box 97
Gadsden, Alabama 35902
(256) 492-0131
www.qolhs.org

COVID-19 VACCINE INFORMATION AND CONSENT FORM

Name:_____
First Middle Last

Address: _____
Street City State Zip

Telephone: (_____) _____-_____ _____
SSN

Date of Birth:	**Age**: _____	**Gender**:	**Primary Language**:	**Ethnicity**: (Check only one)
____-____-_____ (DD) (MM) (YYYY)		☐ Male ☐ Female	☐ English ☐ Other	☐ Not Hispanic ☐ Hispanic ☐ Unknown

Race: (Check only one): ☐ Black/African American ☐ White ☐ More than one race ☐ Asian ☐ Other

INSURANCE INFORMATION

Insurance Provider (Check one): ☐ United Healthcare ☐ PEEHIP ☐ Humana ☐ Medicare ☐ BCBS ☐ Medicaid ☐ Other

Group Number: _____ **Effective Date of Policy**: _____	**Insurance Policy Number, Medicaid, or Medicare Number**:

Card Holder Name: Last First	**Card Holder Date of Birth**	**Relationship to Patient**: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Spouse ☐ Other: _____
Housing Status	**Public Housing Residence**	**School Based Health Care**
Doubling Up	☐ YES ☐ NO	☐ YES ☐ NO
Not Homeless	**FARMWORK STATUS**	
Shelter	Migrant	
Transitional	Not a Farmworker	
Unknown/Reported		

FOR UNINSURED PATIENTS:

☐ By checking this box, I attest that the following 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. I understand that to have my COVID-19 vaccine administration fee paid by the U.S. Health Resources and Services Administration (HRSA) COVID-19 Program for Uninsured Patients, I must provide one of the following: (a) my Social Security Number, (b) my state identification number (with state of issuance), or (c) my driver's license number (with state of issuance).

Number (SSN/ID/License – circle one): **State:**

_____ _____

Vaccine Dose (Check one): ☐ Pfizer 1st dose ☐ Pfizer 2nd dose ☐ Moderna 1st dose ☐ Moderna 2nd dose ☐ Johnson & Johnson 1st dose

If this is your second dose, when did you receive your first dose? (**Date**)_____

If this is your second dose, what vaccine was your first dose? ☐ **Pfizer** ☐ **Moderna** ☐ **Johnson & Johnson** ☐ **Don't Know**