COVID-19 VACCINATION CONSENT

LAST NAME: ________________________**FIRST NAME:** __________________ **MI:** _______

BIRTHDATE: _____/_____/_____ **AGE:** __________ **FEMALE** **MALE**

INSURANCE NAME:________________________**POLICY #:** ___________________________

ADDRESS: ___________________________ **CITY:** _____________ **STATE:** ___ **ZIP:** _______

PHONE: (_____) ________________________ **COUNTY:** ________________________

1. Do you have a history of allergic reaction to any vaccine or injectable therapy?..**YES** **NO**
   (shortness of breath, hives, difficulty breathing, etc…)
2. Do you have allergies to medications, food, yeast or latex? ……………………………………………….……….. **YES** **NO**
3. Have you ever been diagnosed with COVID-19?.. ……...**YES** **NO**
   If so when: ____________________________________
   If you have had COVID-19, did you receive antibody or plasma infusion treatment?..................................**YES** **NO**
4. Do you feel well today? .... ……...**YES** **NO**
5. Are you, or have you recently been told to quarantine due to exposure to COVID-19?………………………**YES** **NO**
6. Are you pregnant ……………………………………………………………………………………**YES** **NO**
7. Are you breastfeeding?.. **YES** **NO**
8. Is this your first COVID-19 vaccination………………………………………………………………… **YES** **NO**
   If not when did you receive your first COVID-19 vaccination?____________________
9. Have you been told you have a compromised immune system?... **YES** **NO**
10. Are you aware that this is a two step process and you will need to receive another injection of this vaccine to reach intended immunity?..**YES** **NO**
11. Do you have questions for the staff today that still need to be answered? ....**YES** **NO**

PLEASE NOTE: CONSENT IS REQUIRED FOR EVERY PATIENT

I acknowledge receipt of the "Notice of Health Information Privacy Practices" for VMH Community & Home Care and understand all information is confidential and can only be released with my consent. **INITIALS:**____________

I have received and read the information sheet for the vaccination(s) and have had the opportunity to ask questions. I understand the benefits and risks of the vaccination(s) being administered. I authorize the healthcare providers of the VMH Community & Home Care to administer vaccination to the patient named above. If applicable, I request that payment of authorized insurance benefits be made directly to the VMH Community & Home Care. I understand if insurance does not cover services that I will receive a bill for services.

SIGNATURE (or Legal Representative if patient under 18 years): ______________________________**DATE:** ____________

OFFICE USE ONLY

<table>
<tr><td colspan="2"><u>Staff- please circle Immunization Admins + Vaccine Admins</u></td></tr>
<tr><td>
COVID-19
Manufacturer ___________________________________
Lot # _______________ Exp:__________________
Administered by:_____________________________
Site of Injection R Delt L Delt R Thigh L Thigh
COVID-19 Vaccine EUA FACT SHEET for Recipients provided
☐
</td><td>
If the person listed on the front page has indicated they have previously received a COVID-19 vaccine:
Vaccine Brand Administered (Pfizer, Moderna, Astra Zeneca, Johnson & Johnson):____
Date first dose administered: Month________Day________Year________
Diagnosis code: Z23
<u>PFIZER</u> <u>MODERNA</u>
Vaccine CPT: 91300 Vaccine CPT: 91301
Dose 1 Admin. CPT: 0001A Dose 1 Admin. CPT: 0011A
Dose 2 Admin. CPT: 0002A Dose 2 Admin. CPT: 0012A
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