Registration and Consent

PATIENT INFORMATION		
LAST NAME/FAMILY NAME	FIRST NAME/GIVEN NAME	MIDDLE NAME
SSN (at least last 4 digits)	BIRTH DATE	BIRTH SEX □ Female □ Male □ Other
PATIENT PHONE NUMBER	PATIENT ADDRESS	

Does the patient identify as any of the following racial/ethnic identities? (Please check all that apply)
❒ American Indian/Alaska Native ❒ Asian ❒ Black or African American
❒ Native Hawaiian/Pacific Islander ❒ White ❒ Other ❒ Prefer not to answer

Is the patient…? ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Prefer not to answer	STATE ID NUMBER Issuing State:

INSURANCE INFORMATION	
NAME OF INSURANCE COMPANY	MEMBER ID NUMBER
BIN and PCN:	RX Group
❒ **I AM UNINSURED**	

For the COVID VACCINE: I know the Food and Drug Administration (FDA) has authorized the emergency use of this vaccine. I know it is not a fully licensed FDA vaccine. I was asked to join the V-SAFE program. The program does health checks on the people who get the COVID-19 vaccine. I know I should report vaccine side effects to the FDA/CDC Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 or https://vaers.hhs.gov/reportevent.html.

I have been given a copy of and have read or had explained to me the information in the Fact Sheet for the appropriate COVID-19 vaccine. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine. **Patient or Parent/Legal Guardian Consent -** I have read or had explained to me the information on the benefits and risks of the immunization indicated below. The risks, contraindications and side effects have been explained to me. I have had a chance to ask questions about these immunizations, the diseases they are intended to prevent and the risks of not being immunized. I hereby consent to the administration of the vaccines for which I have initialed below:**I know that if my chosen vaccine requires multiple doses, it is recommended that I receive the same vaccine each time. I acknowledge that I am responsible for keeping track of how many doses I have received of each respective vaccine and the timing of each dose.**

I am consenting to the: ❒ **PFIZER/BIONTECH COVID-19 VACCINE** (minimum 5 years old primary, 16 years boosters)
❒ **MODERNA COVID-19 VACCINE** (minimum 18 years old)
❒ **JANSSEN COVID-19 VACCINE** (minimum 18 years old)

I certify that the above information is correct to the best of my knowledge. Authorization is granted to release to any insurer such information as may be necessary for completion of ICHS claims. I understand that services shall not be denied based upon my inability to pay.

PATIENT/PARENT SIGNATURE:_____ **Date:**_____

Printed Name, relationship (if signed on behalf of patient):_____

Screening for Vaccines - AGE RESTRICTIONS APPLY

The following questions will help us determine if there is any reason you should not get vaccines today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated; it just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

COVID VACCINE Screening questions	Yes	No	Don't Know
1. 在過去**14** 天內，你是否測試出呈陽性的新冠肺炎**?** Have you tested positive for COVID-19 in the past 14 days?			
2. 在過去**14** 天內，你是否與測試出呈陽性的新冠肺炎病人有過親密的接觸**?** Have you been in close contact with a confirmed COVID case in the last 14 days?			
3. 你是否有新冠肺炎的症狀？例如：發燒，咳嗽，氣促，失去味覺或嗅覺**?** Do you have any of these COVID-related symptoms: fever, cough, shortness of breath, loss of taste and/or smell?			
4.你今天是否生病**?**（除了新冠肺炎的症狀以外） Are you sick today (aside from COVID symptoms)?			
5.你對這些疫苗成分有過敏嗎？脂肪**,** 氯化鉀，磷酸二氫鉀，氯化鈉，磷酸氫二鈉和蔗糖 Do you have an allergy to any of these vaccine components? Moderna and Pfizer: lipids, potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate; Janssen: sucrose, citric acid monohydrate, trisodium citrate dihydrate, 2-hydroxypropyl-β-cyclodextrin (HBCD), polysorbate-80, sodium chloride			
6. 在過去接種疫苗，你是否出現過嚴重的過敏症狀**?** 例如**:** 出疹，瘙癢和呼吸困難**?** Have you ever had a serious reaction (hives, itching, difficulty breathing) to a vaccine in the past?			
7. 你是否曾經出現過與疫苗無關的過敏反應**? (**症狀嚴重的，可能危及到生命的過敏反應**)** Have you EVER had anaphylaxis (severe, potentially life-threatening allergic reaction) NOT related to a vaccine?			
8.你是否有免疫功能低下或者正在服用影響你免疫系統的藥物**?** Are you immunocompromised or are on a medicine that affects your immune system?			
9. 你是否有出血性疾病或者正在服用血液稀釋劑**?** Do you have a bleeding disorder or are on a blood thinner? *(only if receiving Janssen vaccine)*			
10.在過去**90**日內，你是否接受過專門針對**COVID-19**抗體的治療**?(**單克隆抗體或恢復期血漿**)** Have you been treated with an antibody therapy specifically for COVID-19 (monoclonal antibodies or convalescent plasma) within the past 90 days?			
11. 你過去是否曾接種過**COVID**疫苗**?** Have you received a COVID vaccine in the past? ❒ **PFIZER** **Doses Received: ❒1 ❒2 ❒3** ❒ **MODERNA** **Doses Received: ❒1 ❒2 ❒3** ❒ **JANSSEN** **Doses Received: ❒1 ❒2**			
HRSA QUESTIONS			
你是否需要翻譯員**?** Do you need an interpreter?			
在過去 **2** 年中的任何時候，您是否曾是季節性或農民工？ At any point in the past 2 years have you been a seasonal or migrant farm worker?			
你的住房情況是 What is your Housing Situation?: ❒我有房子 I have housing ❒我沒有房子 I do not have housing ❒我寧願不回答 I prefer not to answer			

FOR CLINIC STAFF ONLY: WAIIS reviewed - first dose date: second dose date: third dose date:

Date Vaccine Given	Vaccine Name	SEQ	Product Code			Site/ Route	Administered by Sign/Title	Edition of Current EUA/VIS Offered	Pharm D Initial
			Lot#	Manuf	Dose				
	COVID-19	❒ 1 ❒ 2 ❒ 3		❒ PFIZER ❒ MODERNA ❒ JANSSEN	❒ 0.2 mL ❒ 0.25 mL ❒ 0.3 mL ❒ 0.5 mL	**IM** ❒ L ❒ R			