COVID-19 Vaccine Consent Form

Please print.

Legal Name: _____ Date of Birth: _____

Gender: _____ Race: _____ Ethnicity: _____

SS#: _____ Address: _____
(street address or PO Box) City State ZIP Code

Occupation: _____ Telephone #: _____

E-mail: _____ Allergies: _____

Emergency Contact: _____ Relationship to Patient: _____

Telephone #: _____

COVID-19 Vaccination Screening Questions		Yes	No
1	In the past two weeks (14 days) have you tested positive for COVID-19 or are you currently being monitored for COVID-19?		
2	Have you experienced the following symptoms in the past 24 hours:		
	☐ Fever (a temperature ≥100.4°F or higher) ☐Chills ☐ Muscle pain or body aches ☐ Headache		
	☐ Sore throat ☐ New loss of taste or smell ☐ Nausea and/or vomiting and/or diarrhea		
	☐ Cough (unrelated to a chronic condition) ☐ Shortness of breath (unrelated to a chronic condition)		
3	Have you received any vaccine (via needle or inhaled) within the past two weeks (14 days)?		
4	Have you been diagnosed with COVID-19 AND been treated with monoclonal antibodies or convalescent plasma for treatment of COVID-19 within the last 90 days?		
If patient answers yes to any of these questions, please inform them that they should not receive the vaccine at this time, instruct them to contact their primary care provider for next steps.			
Immunization Screening Questions		**Yes**	**No**
5	Do you have any long-term health problems, such as: • Immunocompromised condition or taking a medicine that affects your immune system • Heart Disease • Lung Disease • Asthma • Kidney or Liver Disease • Metabolic Disease, such as Diabetes • Bleeding Disorder or take a Blood Thinner		
6	Have you had a severe reaction (e.g., anaphylaxis) to any component of the vaccine? [Please refer to Vaccine Fact Sheet]		
7	Have you had a severe reaction (e.g., anaphylaxis) to any vaccine?		
8	Have you had a seizure, a brain/ nervous system problem or Guillain Barre after receiving a vaccine?		
9	For women, are you pregnant or is there a chance you could become pregnant during the next month?		

If you have answered yes to any of the questions 5-9, please consult with your primary care physician on the risks/benefits of receiving the COVID-19 vaccine.

I have read and understand the Emergency Use Authorization (EUA) Fact Sheet or the VIS about the COVID-19 virus and vaccine. I understand the benefits and risks of the COVID-19 vaccine. I give permission for the abovenamed patient to receive the vaccine indicated. I authorize billing insurance for the vaccine administration fee for the vaccine provided. I have also received notice of my privacy rights, and I have been given or offered a copy of the Mobile County Health Department/ Family Health "Notice of Privacy Practices". I understand this information is available upon request, as well as available for review at the time of vaccination.

Signature of person to receive the vaccine or authorized representative or Legal Guardian:

X_____Date: _____

----------Clinical Use Only----------

Vaccine: ____COVID-19_____ Manufacturer: ___Moderna_____ Lot#: _____ Exp date: _____

NDC #: _____Dose: ____0.5 ml_____ Admin Route: __X__ IM_

Site: Deltoid: ____ L ____ R Administered by: _____ Date: _____ Time: _____

_____ Monitoring period completed, and no adverse reaction noted. _____ Recipient declined monitoring period. Waiver completed.

_____ Adverse reaction noted (see attached)

Signature of Observer: _____ Date: _____

Immunization Encounter Form for COVID-19

Patient Information

Private Insurance/Medicaid	Insurance Information
❑ 1. No Insurance ❑ 2. Bill Insurance (Private) ❑ 3. Medicaid (Adult) Medicaid Number _____	Subscriber Name _____ Insurance Company _____ Group Number _____ Policy Number _____ Effective Date _____

Date of Service: _____

Name: _____

Address: _____

City:_____ State _____ Zip_____

Phone:_____ SSN:_____-____-_____

Sex:____ Age: ____Date of Birth: ____/___/___Race:___

Relationship to Subscriber (Circle) self, child, spouse, other

Vaccine		CPT CODE	NDC # Currently on	Vaccine Administration Code	Presentation	Lot Number and Expiration Date
Moderna	Adult	91301	80777-0273-99	❑ 0011A (1st dose) ❑ 0012A (2nd dose)	10 Dose Vial	
Pfizer	Adult	91300	59267-1000-02	❑ 0001A (1st dose) ❑ 0021A (2nd dose)	5 Dose Multidose Vial	

MOBILE COUNTY HEALTH DEPARTMENT
General Consent Form

NAME	STREET ADDRESS	DATE OF BIRTH
CITY	STATE	ZIP
PATIENT NUMBER	[redacted]	[redacted]

FOR FAMILY PLANNING ONLY VISITS

Anyone, regardless of age, is able to sign for themselves for Family Planning services. There is no parental/guardian consent required for Family Planning services. ***

TREATMENT

I give permission for me or the above named individual to receive healthcare (medical, optometry, dental and mental health) services provided by the Mobile County Health Department (MCHD). This consent includes healthcare services such as physical and mental health examinations, laboratory tests (including tests for sexually transmitted diseases (STDs) and HIV infection by antibody test, routine immunizations, and other healthcare treatments or preventive healthcare activities, as deemed necessary by clinical healthcare providers and dentists.

I understand that health information concerning me or the above named individual may be released to any healthcare worker within the Mobile County Health Department who is involved with my care or the care of the individual named above. Additionally, if necessary, I authorize the Mobile County Health Department to make referrals, which may contain any and all of my or the above named individual's health information, including but not limited to sexually transmitted diseases, to outside providers in order to aid in the treatment of my or the above named individual's particular health condition or potential health condition.

I hereby give permission to the Alabama Department of Public Health to disclose information about me/this minor child to social service agencies, community agencies, and health care providers for the limited purpose of consultation or referral. This permission may include the disclosure of information about my/this child's medical condition but does not include the release of the written medical record.

I have been given an opportunity to discuss how this form will be used. I know that I have the right to revoke this permission at any time (except to the extent that action has already been taken). Unless otherwise revoked, this authorization will expire one year from the date signed.

I understand that if an invasive procedure or a permanent tooth extraction is required as part of my treatment or the treatment of the individual named above that I will be provided an opportunity to sign a separate informed consent form for that particular treatment or test and for no other treatment or test. The informed consent will explain the procedure or test to be performed and the associated benefits and risks.

I understand and agree that, if I invite a family member, friend or other person into the exam room with me, I consent to the sharing of my or the above named individual's protected health information with that family member, friend or other person who is present.

***** FAMILY PLANNING**

I understand that Family Planning services are confidential and my information may not be disclosed without my consent except as required by law. I understand that the Family Planning Program offers services for me to accept on a voluntary basis and that I cannot be coerced (pressured) in any way to receive services or to use any particular method of family planning. I understand that if I do not want family planning services, I can still receive any other service offered.

PAYMENT

I authorize the release of any and all relevant health information concerning me or the individual named above to process a claim and request payment from Medicaid, Medicare, other third party insurance carriers, or other guarantors or payers, either to me or to the Mobile County Health Department.

I understand that I am financially responsible for payment of any health insurance deductible, co-payment or non-covered service(s). I agree to comply with MCHD's financial policies and provide my co-payment at the time of service. I acknowledge that some or all medical services I receive today may not be covered by my health insurance provider and do agree to promptly pay any remaining charges not covered by insurance, including any outside laboratory fees.

HEALTH CARE OPERATIONS

I authorize, as needed, the release of my or the above named individual's health information to an outside copying service for photocopying, microfilming, and/or forwarding this health information to third parties.

I also authorize the release of my or the above named individual's health information for routine healthcare operations such as assessing and reviewing the quality of care received and the competency of healthcare professionals working at or on behalf of the Mobile County Health Department.

I understand and have been provided with a copy of the Mobile County Health Department's Notice of Privacy Practices that provides a more complete description of the uses and disclosures of my or the above named individual's health information.

In consideration of the healthcare services being provided to me or the above named individual, I hereby agree to release the Mobile County Health Department, its board members, directors, officers, employees, agents and volunteers from any legal liability for providing me or the above named individual with healthcare services.

I understand that the State of Alabama allows me to consent for treatment if I am 14 years of age or older, and that if I am this age or older and I do not require any other consent, that I am the sole owner of my health information and that I am the only one authorized to release such information.

I consent to receiving text messages on my cell phone for appointment, general health and bill balance reminders. MCHD does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan. I may withdraw my consent or refuse to receive text messages at any time by checking the "no" box below. I understand that text messaging is not secure and may be seen by third parties and that text messaging has a number of risks associated with it including the following: text messages may be misaddressed, intercepted, altered, forwarded or used without authorization or detection.

☐ YES, CELL PHONE NUMBER: ☐ NO

Signature of Patient, Parent or Legal Representative

PRINT name of Patient, Parent or Legal Representative

PRINT name of Witness

Date

For Medicaid Patients

A patient signature is required of all Medicaid patients as verification of services rendered on date of claim. This signature must be kept in the patient's health record. Signatures are not required under the following circumstances: (1) When the patient is illiterate; in this case an "X" may be signed by patient in front of a witness that has seen the marking (witness must attest to marking with signature and date); (2) Patient is not competent to sign because of age, mental or physical impairment.

MOBILE COUNTY HEALTH DEPARTMENT
PRIVACY NOTICE ACKNOWLEDGEMENT FORM

About Our Notice of Privacy Practices

We are committed to protecting your health information in compliance with the law. The attached Notice of Privacy Practices states:

- our obligations under the law with respect to your health information
- how we may use and disclose the health information that we keep about you
- your rights relating to your personal health information
- our rights to change our Notice of Privacy Practices
- how to file a complaint if you believe your privacy rights have been violated
- the conditions that apply to uses and disclosures not described in this Notice
- the person to contact for further information about our privacy practices

We are required by law to give you a copy of this notice and to obtain your written acknowledgement that you have received a copy of this notice.

Patient Acknowledgement of Receipt

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____
Patient's Signature Date

_____ _____
Signature of Parent or Patient's Representative (if applicable) Date

_____
Description of Legal Authority to Act on Behalf of Patient

0040189527 Vaccine info sheet to be completed by patient Date: ____/____/_____

◯ First Dose ◯ Second Dose

Please fill in circles completely

What is your age group (in years)? ◯ Under 16 ◯ 16-17 ◯ 18-30 ◯ 31-64 ◯ 65-75 ◯ 75-85 ◯ Over 85

What is your race and ethnicity (Select ALL that apply)?

◯ American Indian or Alaska Native ◯ Asian or Pacific Islander ◯ Black or African American
◯ Hispanic or Latino ◯ White or Caucasian

Select ALL that apply to you:

◯ I am a healthcare worker or work in a healthcare setting (paid or unpaid)

Facility type/Setting:

- ◯ Inpatient
- ◯ Outpatient
- ◯ Long term care facility
- ◯ Home health/hospice
- ◯ Laboratory
- ◯ Other

Primary activities:

- ◯ Direct patient care
- ◯ Indirect patient care
- ◯ Support

◯ I am an Emergency Medical Services (EMS) provider

◯ I am a Mortuary Services Provider

◯ I am a First Responder (non-EMS)

- ◯ Law Enforcement
- ◯ Fire Services
- ◯ Corrections Officer
- ◯ Other

◯ I live or work in a congregate or group setting (examples: Group home, Shelter, Correctional Facility)

◯ I have a condition that puts me at higher risk of severe illness or death from COVID-19*

◯ I work (paid or unpaid) in a K-12 school (include educators, administrators, bus drivers, support staff)

◯ I work in one of the following industries or settings: Food and Agriculture, Transportation and Logistics, Manufacturing, Public Safety, Food Service, Energy, Water and Wastewater, Legal, Media, Finance, Public Health

◯ None of the above apply to me

*Cancer, Chronic Kidney Disease, COPD, Heart conditions, Immunocompromised, Obesity, Severe Obesity, Pregnancy, Sickle Cell Disease, Smoking, Type 2 diabetes mellitus, Asthma, Cerebrovascular disease, Cystic fibrosis, High Blood Pressure, Neurologic conditions such as dementia, Liver disease, Overweight, Pulmonary fibrosis, Thalassemia, Type 1 diabetes mellitus