COVID-19 VACCINE CONSENT

PLEASE PRINT

CHECK OUT TIME: ___________

☐**1ST DOSE DATE**________ ☐IMMPRINT

☐**2ND DOSE** ☐ATHENA

NAME	**DATE OF BIRTH**	GENDER: ☐ MALE ☐ FEMALE
STREET ADDRESS	**CITY / STATE / ZIP**	**SOCIAL SECURITY NUMBER**
OCCUPATION	**TELEPHONE #**	☐ **HISPANIC** ☐ **NON-HISPANIC**
EMAIL	☐ **BLACK/AFRICAN AMERICAN** ☐ **WHITE/CAUCASIAN** ☐ **ASIAN** ☐ **MORE THAN ONE RACE** ☐ **NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER** ☐ **AMERICAN INDIAN/ALASKA NATIVE**	
EMERGENCY CONTACT & EMERGENCY PHONE #	RELATIONSHIP TO PATIENT	ALLERGIES
INSURANCE COMPANY: ☐NO INSURANCE	INSURANCE SUBSCRIBER NAME	INSURANCE GROUP #
INSURANCE POLICY #	INSURANCE EFFECTIVE DATE	RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ CHILD ☐ SPOUSE ☐ OTHER

	COVID-19 VACCINATION SCREENING QUESTIONS	YES	NO
1	HAVE YOU TESTED POSITIVE FOR COVID-19 IN THE LAST 10 DAYS 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 ☐ SORE THROAT		
	☐ MUSCLE PAIN OR BODY ACHES ☐ HEADACHE ☐ 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 THE PATIENT ANSWERS YES TO ANY OF THESE QUESTIONS, PLEASE INFORM THEM THAT THEY SHOULD NOT RECEIVE THE VACCINE AT THIS TIME.		
	GENERAL 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 BLOOD THINNER		
6	HAVE YOU HAD A SEVERE REACTION (E.G., ANAPHYLAXIS) TO ANY COMPONENT OF THE VACCINE? [PLESE REFER TO THE 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

SIGN: ______________________________ DATE: ______________________

CLINICAL USE ONLY

VACCINE:	MANUFACTURER:	**LOT:**	EXP DATE:
NDC#:	DOSE:	ADMIN ROUTE: IM	**SITE: DELTOID: ☐L ☐R**
GIVEN BY:	**MONITORING PERIOD** ☐COMPLETED, AND NO ADVERSE REACTION NOTED		
DATE:	☐RECIPIENT DECLINED MONITORING PERIOD		
TIME:	☐ADVERSE REACTION NOTED (ATTACH VAERS & INCIDENT REPORT)		

SIGNATURE OF OBSERVER: ______________________________ DATE: ______________________

MOBILE COUNTY HEALTH DEPARTMENT
General Consent

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 Mobile County Health Department 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.