COVID VACCINE CONSENT FORM (existing clients)

RECIPIENT Last_________________________ First_________________________ DOB_______________

Facility Name_________________________ Gender ☐ M ☐ F

Race: ☐ Asian ☐ Black ☐ Am Indian ☐ Caucasian ☐ Pacific Islander ☐ Other

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to State

INSURANCE INFORMATION

NOTE: Residents who do not get medications from Forum, copy of insurance card required. If dose is not covered by insurance, facility will be billed including administration fee.

Insurance Plan Name_________________________Group#_________________________ID#_________________________

SSN_________________________DL/State ID#_________________________ Medicare ID#_________________________

Screening Questions (Please check appropriate boxes)

1. Sick or feverish today? YES ☐ NO ☐ Unknown ☐
2. Have history of anaphylaxis or have had allergy or reaction to vaccines, injectable therapy, or anything else? (Food, medicine, latex, polyethylene glycol, etc.), including fainting or feeling dizzy? YES ☐ NO ☐ Unknown ☐
   If yes, please provide details: _________________________
3. Allergic to any ingredient in the vaccine? YES ☐ NO ☐ Unknown ☐
4. Currently have COVID or symptoms of COVID? YES ☐ NO ☐ Unknown ☐
5. Ever had a seizure disorder for which you are on seizure medication(s), brain disorder, Guillain-Barre Syndrome, or other nervous system problem? YES ☐ NO ☐ Unknown ☐
6. Have a history of myocarditis or pericarditis? YES ☐ NO ☐ Unknown ☐
7. Received a vaccine other than for COVID within the last 30 days? YES ☐ NO ☐ Unknown ☐
8. Been treated with antibody therapy for COVID (MABs or convalescent plasma) within the last 90 days? YES ☐ NO ☐ Unknown ☐
9. Have you ever received a dose of COVID-19 Vaccine? YES ☐ NO ☐ Unknown ☐
   If yes, which product did you receive? Pfizer Moderna Other __________ Date:_________

CONSENT

I consent to the administration of the Covid vaccine by a pharmacist or other authorized person employed or contracted by Forum Extended Care Services for which I am due or eligible to receive. I have received and read the CDC Vaccine Information Statement about Covid. I have had a chance to ask questions and have had the opportunity to have all my questions answered to my satisfaction. I understand the benefits and risks of the Covid vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to make the request. I authorize release of any medical information or other information necessary to process an insurance claim and for other health care operations. I understand and authorize claim submission on my behalf to Medicaid, Medicare, and/or commercial insurance for payment of covered services and assign benefit payments to be made to Forum Extended Care Services. I authorize disclosure of the vaccination information to public health officials, state immunization registry and/or other health care professionals. I, as well as the patient and his or her heirs, executors, personal representatives, and assigns, will not hold the above-named healthcare facility or facility nursing staff liable for any harm caused by my receiving Covid vaccine and waive any claim for damages that I may have against said facility, its directors, officers, employees, agents, or business associates on account of any loss, injury, death or damage I may suffer as a result of receiving the Covid vaccine. I have been advised to remain near the vaccination area for observation for 15-30 minutes. I certify that I am the patient and of legal age, or patient's guardian/personal representative signing on behalf of the patient and have read, understand, and agree to all statements on this form.

Recipient Signature _________________________ Date _______________

If other than resident, authorized representative's name (print) _________________________ Date_______________

FOR HEALTHCARE PROFESSIONAL USE ONLY

Reviewed patient information and screening questions Initials: _________

Confirmed patient's name, DOB, and requested vaccine Initials: _________

Provided recipient/caregiver(s)/facility representative the VIS Initials: _________ Date on VIS Sheet _______________

MGF/Dose	Lot#	Vaccine BUD Date	Vaccine Expiration Date	Site of Administration (IM)
Pfizer 0.3ml Moderna 0.5ml				R-Arm L-Arm

Administration Date _______________ Name of Vaccine Administration Company:_________________________

Immunizer's Name (Print) _________________________ Signature _________________________ Title _______________

License #:_________________________ NPI#_________________________