COVID/FLU Vaccine Intake Consent

Clinic Information

Keystone Care at Holy Martyrs Catholic Church

Clinic Name

120 Allison Rd	Oreland	PA	19075
Address	City	State	Zip

Patient Information

Last Name	First Name	Date of Birth	Gender	Phone #

Address	State	City	Zip

Race: **1** - American Indian or Alaska Native **2** - Asian **3** - Native Hawaiian/Other Pacific Islander **4** - Black or African American **5** - White **6** - Other Race

Ethnicity: ◯ **1** - Hispanic ◯ **2** - Not Hispanic or Latino ◯ **3** - Unknown

PLEASE SELECT WHICH VACCINES YOU WILL BE RECEIVING AND INDICATE WHICH DOSE

*please note, you may receive the flu vaccine and a COVID vaccine at the same time today

COVID-19 Vaccine	Flu Vaccine
DOSE:_____ ___ Pfizer Bivalent Booster ___ Moderna Bivalent Booster ___ Pfizer Original Formula ___ Moderna Original Formula ___ Vaccine for Child: Please specify_____	___ Under 65-year-old ___ Over 65-year-old (High- Dose)

Insurance Information:

Medical Insurance:

◯ Yes ◯ No

_____

*Medicare Part A/B ID Number (MBI)

Note: *MBI is required for all patients age 65 and older, or Medicare eligible. Refer to your Medicare Red, White, and Blue card*

OR:

_____ _____

Medical Insurance Pro-vider Cardholder/ Member ID #

Health Screening Questions

IF RECEIVING COVID VACCINE Please notify nurse if any options below apply to you today, or initial next to first option

_____NONE of the below apply to the patient today

- Patient is feeling sick today
- Patient has received another vaccine in the last 14 days
- Patient has a history of severe allergic reaction (eg anaphylaxis)? For example a reaction for which the patient was treated with epinephrine or EpiPen or for which patient had to go to the hospital?
- Patient has received monoclonal antibodies or convalescent plasma for COVID-19 treatment within the past 90 days or post exposure prophylaxis within the past 30 days.
- Patient has a bleeding disorder or is taking a blood thinner
- Patient has a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies
- Patient is pregnant or breastfeeding

IF RECEIVING FLU SHOT, please answer questions below

1. Have you had a flu shot before? ____YES ____NO

2. Are you allergic to thimerosal, eggs, or egg products? ____YES ____NO

3. Have you ever had an allergic reaction to flu or other vaccine? ____YES ____NO

4. Is there a chance you are pregnant? ____YES ____NO

The flu shot is considered safe for pregnant women over 12 weeks, breastfeeding women and their infants and is recommended for women who will be pregnant during flu season since they are at risk for flu-related complications.

5. Are you currently sick with fever (does not include minor illnesses)? ____YES ____NO

6. Do you have a history of Guillain-Barre Syndrome? ____YES ____NO

Consent and Administration

Consent for Flu Services: I have received and read the informed consent for the flu vaccination, and I wish to receive and have had the opportunity to ask questions. I accept that services might be rendered in a non-private setting. I hereby consent to the administration of the flu vaccine. Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators and assignees, KeystoneCare and their employees, owners, and representatives, as well as the company sponsoring this event and their agents, actions and causes of action, which may result from participation in this program. I will communicate the information provided to me today about my vaccination to my primary care provider if I have one.

CONSENT FOR COVID VACCINE SERVICES: I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: contact doctor, call 911. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize KeystoneCare Home Health LLC ("KeystoneCare") to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, or the HRSA

COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that KeystoneCare may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at KeystoneCare (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that KeystoneCare will use and disclose my health information as set forth in the KeystoneCare Notice of Privacy Practices (copy is available by requesting a paper copy from KeystoneCare). Vaccine Clinics: If I am receiving a vaccine through a vaccine clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator.

X

Signature of patient to receive vaccine (or parent, guardian, or authorized representative) Date

If signing on behalf of the patient, you are stating that you are authorized to provide the required consents on behalf of the patient.

Name of parent, guardian, or authorized representative

Phone Number
Relationship

Vaccine Administration Information for Immunizer use only

COVID:

Administration Date	Vaccine	VIS Date	Manufacturer	Volume (mL)
		IM Injection	L R	
Lot #	Exp. Date	Route	Site	

If patient's body temperature is 100.4˚F or greater, inform them they should not receive the vaccine

Patient Temperature

FLU

Administration Date	Vaccine	Lot	IM Injection Site

Administering Immunizer Name & Title

Administering Immunizer Signature