INFORMED CONSENT FOR COVID-19 VACCINE

☐ **1st Dose Consent** ☐ **2nd Dose Consent**

Last_____ **First**_____ **Room/Apt#**_____

DOB_____ **Clinic Site**_____

Recipient ☐ Resident ☐ Non-Resident

Gender ☐ M ☐ F

Race ☐ Asian ☐ Black ☐ American Indian ☐ Caucasian ☐ Pacific Islander ☐ Other

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

Has recipient been PREVIOUSLY vaccinated with COVID-19 vaccine? YES ☐ NO ☐

If YES, which vaccine? ☐ Pfizer ☐ Modern ☐ Janssen/J&J Date of 1st dose _____/_____/_____

NON-RESIDENT ONLY

Home Address_____ City_____

ST_____ ZIP_____ County_____ Phone_____

INSURANCE INFORMATION (*Copy of card required*)

Insurance Plan Name_____

Group#_____ ID#_____

SSN_____ *OR* DL/State ID#_____

Medicare ID#_____

If Not Insured: I attest recipient does not have medical or pharmacy insurance ☐ Yes

RECIPIENT SIGNATURE _____ Date_____

IF OTHER THAN RECIPIENT, Authorized Legal Representative

Name (print)_____ Phone_____

Signature_____ Date_____

IF RESIDENT IS UNABLE TO SIGN, Verbal Consent Must be Verified by Two Witnesses

Witness 1: Signature _____ Date _____

Name and Title (print) _____

Witness 2: Signature _____ Date _____

Name and Title (print) _____

FAX COMPLETED PAGE 1 TO: 800-447-7167

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CONSENT: *I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to Forum Extended Care Services (FECS) and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s)) I have requested above. I understand that it is not possible to predict all possible side effects/complications associated with receiving vaccine(s). I understand the risks/benefits associated with the above vaccine(s) and have received, read and/or had explained to me the EUA Fact Sheet or VIS of the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15-30 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Center for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or as permitted by my state law. I understand that, depending on my state's law, I may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV), and mental health information, to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at time of service or, if the applicable Provider invoices me after time of service, upon receipt of such invoice. FECS may disclose your vaccination information from this visit for public health purposes and will send this information to the Medical Director (if applicable) or Administrator (or equivalent) of the LTCF identified above. If you are an employee of a LTCF, FECS*

Forum 50 YEARS+ EXTENDED CARE SERVICES

☐ 1st Dose Consent ☐ 2nd Dose Consent

SCREENING/ADMINISTRATION ON COVID-19 VACCINATION DAY

Recipient Name _____ _____ Date of Birth _____

SECTION B Questions for Discussion ON CLINIC DAY *(Please check appropriate boxes):*

Is the person to be vaccinated:

1. Been treated with antibody therapy for COVID-19 (MABs or convalescent plasma) within the last 90 days? 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? If yes, please provide details: _____ YES ☐ NO ☐ Unknown ☐
3. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barre Syndrome (a condition that causes paralysis) or other nervous system problem? YES ☐ NO ☐ Unknown ☐
4. Allergic to any ingredient in the vaccine? YES ☐ NO ☐ Unknown ☐
5. Received a vaccine other than for COVID-19 within the last 30 days? YES ☐ NO ☐ Unknown ☐
6. Sick or feverish today? YES ☐ NO ☐ Unknown ☐
7. Currently have COVID-19 or symptoms of COVID-19? YES ☐ NO ☐ Unknown ☐

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient or representative of; or (c) a representative of the LTCF and, based upon clinical observation, have sufficient knowledge of the patient's condition to answer the Screening Questions. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

Signature _____ **Date** _____

Name (please print) _____

SECTION C FOR HEALTHCARE PROFESSIONAL USE ONLY ON CLINIC DAY

Complete BEFORE administration:

1. I have reviewed the Patient Information and Screening Questions. Initial: _____
2. I have verified the expiration date is greater than today's date and have entered the LOT# and expiration date in the section below. Initial: _____
3. Did this person refuse to provide insurance information when I attempted to obtain the insurance information? YES ☐ NO ☐
4. I confirm(ed) the patient's Name, DOB and requested vaccine, and verified it matches the information on the VAR form. Initial: _____
5. I provided a VIS/EUA Fact Sheet to the patient or LTCF representative. Initial: _____

Vaccine	COVID-19 Exp Date	Lot#	Vaccine Beyond Use Date	Manufacturer	Dosage	Dose #	Site of Administration
COVID-19				Pfizer-BioNTech	0.3 mL IM	☐ 1	☐ L-Arm ☐ R-Arm
						☐ 2	☐ L-Arm ☐ R-Arm
COVID-19				Moderna	0.5 mL IM	☐ 1	☐ L-Arm ☐ R-Arm
						☐ 2	☐ L-Arm ☐ R-Arm
COVID-19				Janssen/J&J	0.5 mL IM	1	☐ L-Arm ☐ R-Arm
COVID-19				Other: _____	_____ mL IM	☐ 1	☐ L-Arm ☐ R-Arm
						☐ 2	☐ L-Arm ☐ R-Arm

***Note records to be stored for 7 years.*

Clinician's Name (Print) _____ Clinician's Name (Signature) _____ Title _____

Administration Date _____ Date VIS/EUA Fact Sheet Given _____ VIS/EUA Fact Sheet Publish Date _____

Diluent LOT # (if applicable) _____ Diluent Expiration Date (if applicable):_____

VACCINE RECORD — FAX COMPLETED PAGE 2 TO 800-447-7167#

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