

Pediatric COVID-19 Vaccine Consent Form

PATIENT INFORMATION				
Patient's LEGAL Last Name:	Patient's LEGAL First Name:	Phone Number:	Age:	Birthdate:
Street Address:	City:	County:	State:	Zip Code:
Assigned sex at birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Race: (Select one or more) <input type="checkbox"/> AS-Asian/Pacific Islander/Other <input type="checkbox"/> BL-Black or African American <input type="checkbox"/> CH-Chinese <input type="checkbox"/> CA-Caucasian (White)/Mexican/Puerto Rican <input type="checkbox"/> FI-Filipino <input type="checkbox"/> HA-Hawaiian <input type="checkbox"/> IN-Native American/Alaska Native <input type="checkbox"/> JA-Japanese <input type="checkbox"/> NW-Other Non-White <input type="checkbox"/> UN-Unknown			
Are you Hispanic or Latino <input type="checkbox"/> Yes <input type="checkbox"/> No				
Insurance Company or Medicare:	ID#:	Group# (Insurance Only):	Primary Physician:	

VACCINATION SCREENING QUESTIONNAIRE	
1. Is the patient currently sick or experiencing a high fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the patient had a life threatening allergic reaction to any vaccine or other injection in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does the patient have any allergies to Benadryl, solumedrol, epinephrine, polysorbate, Polyethylene glycol, or prior COVID-19 vaccine? Please list:	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has the patient received any other vaccine in the past 14 days? List:	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has the patient been diagnosed with COVID-19 in the past 90 days? If yes, did you receive passive antibody therapy or plasma as part of their treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the past 3 months, has the patient taken medications that weaken their immune system, such as cortisone, Prednisone, other steroids, or anti-cancer drugs, or had radiation treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Does the patient have a health problem with lung, heart, history of myocarditis, kidney, diabetes, asthma, thrombosis-thrombocytopenia syndrome (TTS), a blood or bleeding disorder, or on a blood thinner? Circle any medical condition that applies to the patient.	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Will the patient have a birthday between the 1 st and 2 nd dose of the COVID-19 Vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Has the patient previously received a COVID-19 vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please select: <input type="checkbox"/> Pfizer <input type="checkbox"/> Other: _____ Date: _____	
11. Has the patient had an adverse reaction to any COVID-19 vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
12. If you answered yes to #11, did the adverse reaction require emergency medical attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Please read and check each of the following statements then sign.

- I have been offered a copy of the Vaccine Fact Sheet EUA for the COVID-19 vaccine checked below, whether accepted or not. I have read or had explained to me the information in the Fact Sheet, including the possible adverse reactions, the components of the vaccine, the possible risks, and what to do after the vaccination.
- I ask that the vaccine be given to the person named above for whom I am authorized to make this request. I consent to the inclusion of this immunization data in the Kansas Immunization Registry for the above named person.
- I understand the importance of remaining in the clinic for 15 minutes after receiving this vaccine. I understand that there is an increased risk of allergic reactions and syncopal episodes within the first 15 minutes after a vaccination, and if I choose to leave the facility, I assume responsibility for this risk.
- I do hereby solemnly swear that I have legal custody of the aforementioned minor. I grant authorization and consent for Saline County Vaccination Collaboration to administer the COVID-19 vaccine to the above named minor and provide medical evaluation and treatment throughout the vaccine process, including administration of medications and calling EMS for transport to the nearest emergency department.

Signature of Parent/Guardian: _____

Date: _____

Staff use only:

VACCINE	DOSE	EXT	SITE	ROUTE	MANUFACTURER	LOT #	EXP DATE
Pfizer	0.2 ml. 1 2	RT LT	Deltoid Vastus Lat	IM	Pfizer		

Signature and Title of Vaccine Administrator _____ Date Given _____

SALINA FAMILY HEALTHCARE CENTER Chart #: _____
NEW & ANNUAL PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Legal Name:	DOB:
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Assignment of Benefits and Authorization to Release Medical Information:
 I request that payment of authorized benefits from Medicare, Medicaid, and/or any insurance carrier applicable, be made to me, or on my behalf, to Salina Family Healthcare Center, for any services, including, but not limited to, telemedicine and/or teledentistry, furnished to me and/or my dependent family members by my provider. I authorize any holder of medical/dental information about me and/or my family members to release it to the Division of Family Services, the Centers for Medicare and Medicaid Services (CMS), applicable insurer(s), and/or agent of these companies, and/or the listed responsible person(s), and information needed to determine these benefits or the benefits for other related services.

Immunization Consent:
 I give consent for my child to receive all immunizations recommended by the Center for Disease Control. I understand that this clinic follows the Center for Disease Control’s guidelines for schedules, doses, and particular vaccines in administering these immunizations. I understand that this consent is applicable if I am filling out this form on behalf of a minor child.

Financial Account Policy:
 By my signature below, I am agreeing to the Financial Account policies set forth by Salina Family Healthcare Center. A detailed description of the Financial Account Policy is available for all patients, upon request.

Disclosure of Insurance Coverage:
 I have also disclosed all insurance coverage in effect at the time services were provided to me. I understand that failure to inform Salina Family Healthcare Center of any third party insurance coverage will be considered fraud and I understand that the clinic will prosecute to the fullest extent of the law.

Acknowledgement of Services:
 By signing below, I acknowledge that Salina Family Healthcare Center provides an integrated care model where behavioral health screenings and consults will be part of the patient-centered care provided.

Patient and Center Rights and Responsibilities:
 I acknowledge that I have received a copy of Salina Family Healthcare Center’s Patient and Center Rights and Responsibilities form. We ask you acknowledge your receipt of this document by signing below. You should keep a copy of the Center’s Patient and Center Rights and Responsibilities; however, if you wish to receive another copy you may request a copy at any time. The most current copy of Center’s Patient and Center Rights and Responsibilities will be posted in our office. I acknowledge that I received a copy of Center’s Patient and Center Rights and Responsibilities effective May 19, 2016.

Notice of Privacy Practices
 Maintaining privacy of your health information is very important to us. You have been asked to review our Notice of Privacy Practices. We ask you acknowledge your receipt of this Notice by signing below. You should keep a copy of the Notice; however, if you wish to receive another copy you may request a copy at any time. The most current copy of this Notice will be posted in our office. I acknowledge that I received a copy of my Center’s Notice of Privacy Practices effective July 7, 2016.

Patient/Legal Guardian Signature:	Today’s Date:
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For Office Use Only
Form Processed by: _____