COVID-19 IMMUNIZATION CONSENT AND CLAIM FORM

INCOME INFORMATION

How many members are there in your family? ____________

What is your annual household income (this includes spouse / partner)? ______________________

MRN

MONITORING TIME

☐ 15 mins ☐ 30 mins

INSURANCE INFORMATION

☐ Medicare Part B

#______________________

☐ Oregon Health Plan (Medicaid)

#______________________

☐ ______________________
Name of insurance company

____
Member #

______________________ ______________________
Subscriber Name Subscriber Date of Birth

PATIENT INFORMATION (PLEASE PRINT)

Parent/Guardian Full Name: ______________________

Last Name:	First Name:	MI:
Date of Birth: (mo/day/yr) ____/____/____	Phone#: (_____) _____–________	Sex: ☐ F ☐ M

Street and/or Mailing Address:

City:	State:	Zip:	Primary Language:

Race: (Check all that apply) ☐ African American ☐ American Indian/ Alaskan Native ☐ Asian ☐ Native Hawaiian/ Pacific Islander ☐ White ☐ Decline to Answer

Ethnicity: Hispanic? ☐ Yes ☐ No ☐ Decline

Question	Yes	No	Don't Know
1. Do you have a fever or feel sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Other	☐	☐	☐
3. Do you have any allergies to eggs, medicines, foods, latex, or vaccines?	☐	☐	☐
4. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?	☐	☐	☐
5. Was the severe allergic reaction after receiving a COVID-19 vaccine? (See Fact Sheet)	☐	☐	☐
6. Was the severe allergic reaction after receiving another vaccine or another injectable medication?	☐	☐	☐
7. Have you had a severe allergic reaction to any ingredient of this vaccine? (See Fact Sheet)	☐	☐	☐
8. Have you received another vaccine in the past 14 days? If yes, which one(s)? ______________________	☐	☐	☐
9. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
10. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
11. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
12. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia, another blood or bleeding disorder, or are taking a blood thinner?	☐	☐	☐
13. Has the patient ever fainted after injections?	☐	☐	☐
14. Are you pregnant, do you plan to become pregnant, or are you breastfeeding?	☐	☐	☐

I have read/had explained to me the information about COVID-19 and the COVID-19 vaccine and have received the Fact Sheet. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the COVID-19 vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I agree that the OHA COVID-19 vaccine-enrolled provider shall have no responsibility or liability if I contract COVID-19, or other respiratory diseases, or suffer any other adverse reaction following administration of the COVID-19 shot. I allow the release of any information needed to process insurance claims or request payment of medical benefits.

X Signature of responsible person: ______________________ Date: ____________

Nurse ______________ **Clinic Location:** ______________ **Date:** ______________

Dose: .3 .5 **Site:** RDIM LDIM RVLIM LVLIM ☐ Entered in EPIC ☐ Not Entered in EPIC

MODERNA (CPT 91301 | Admin 0011a)

Lot	Date
047B21A	10/9/21
007C21A	10/12/21
021C21A	10/21/21
027C21A	10/26/21
037C21A	11/2/21

JANSSEN (CPT 91303 | Admin 0031a)

Lot	Date
1805018	5/25/21
043A21A	6/21/21
206A21A	6/23/21

Rev. 5/7/21