Tri-City Community Health

COVID-19 Vaccine Patient Acknowledgment

Patient Name (Last, First): _____ DOB: ___/___/_____

Phone: _____ Mobile Phone: _____ Email: _____
(This information will be used to contact you for your second dose reminder.)

Address: _____ City, State, Zip Code: _____

Information collected in this section helps ensure we deliver equitable and patient-centered care:
Sex listed at birth (check one):

Male: ☐	Female: ☐

Gender identity (check one):

Male: ☐	Female: ☐	Non-Binary ☐	Unspecified/Indeterminant: ☐

Ethnicity (Check one):

Hispanic or Latino (Including Spanish, Mexican, Puerto Rican, Cuban, etc. ☐	Not-Hispanic A person not of Spanish culture or origin ☐

Race: (Check all that apply):

Black or African American ☐ White ☐	Asian ☐ American Indian or Alaska Native ☐	Hawaiian or Pacific Islander ☐

Preferred language:

English ☐	Spanish ☐	Russian ☐	Ukrainian ☐	Vietnamese ☐	Tagalog ☐	Other: _____ ☐

Insurance Information:

Insurance company: _____ Are you the primary card holder? Y N

If no, what is the primary card holders name and date of birth? _____

Cardholder ID: _____ Rx Group ID: _____

BIN: _____ PCN: _____

Are you Medicare eligible? Y N If yes, Medicare Part A/B number: _____

If you are not insured and you do not want to pay for administration of the vaccine yourself, you must provide the information below. If you do not provide this information you may be billed for vaccine administration.

I do not have any insurance, including but not limited to Medicare, Medicaid, or any other private or government-funded health benefit plan. In order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program for Uninsured Patients please provide (a) a valid Social Security number, or (b) state identification number and state of issuance, or (c) a driver's license number and the state of issuance: _____

Acknowledgements:

- *I made the choice to get the COVID-19 vaccine on my own and freely. I know I have the option to refuse the vaccine. I ask that the vaccine be given to me, or to the person named above for whom I can make this request. I was given the (Fact Sheet for Vaccine Recipients and Caregivers)* for this vaccine. The fact sheet *has information about side effects and adverse reactions. I read or had read to me the information provided about the COVID-19 vaccine.*

- *I know the Food and Drug Administration (FDA) has authorized the emergency use of this vaccine. I know it is not a fully licensed FDA vaccine. I had the chance to ask questions that were answered to my satisfaction. I now know about the vaccine, alternatives, benefits, and risks, to the extent they are known and unknown at this time.*

- *I know that I must stay in the vaccine area or an area told to me by my health care provider after I receive my immunization so I am near my health care provider if I have any adverse reactions.. If I have a history of certain allergic reaction(s), I must stay for 30 minutes. If I do not have a history of such an allergic reaction(s), I must stay for 15 minutes.*

- *I know that if I have a severe allergic reaction, including difficulty breathing, swelling of my face and/or throat, a fast heartbeat, a bad rash all over my body or dizziness and weakness I should call 9-1-1 or go to the nearest hospital. I know I can call my health care provider if I have any side effects that bother me or do not go away.*

- *I was asked to join the V-SAFE program. The program does health checks on the people who get the COVID-19 vaccine. I know I should report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 or https://vaers.hhs.gov/reportevent.html.*

- *I know that with all vaccines there is no promise I will become immune (not get the virus) or that I will not have side effects.*

- *If my COVID-19 vaccine is a two dose vaccine, know I must get two doses and receive the same vaccine each time. I know I may choose to not get the second dose of the vaccine. But if I do not get the second dose, the chance that I will become immune may go down.*

Authorization to Request Payment: *I authorize the organization providing my vaccine 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 the organization providing my vaccine may be required to or may voluntarily disclose my vaccine-related health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also understand the organization providing my vaccine will use and disclose my health information as described in its Notice of Privacy Practices which I may receive upon request or find on its website. If I am an employee of Tri-City Community Health. I understand that it will keep records of this vaccination for me in WAIIS and may keep my vaccination records in [insert name of health care provider]'s employee occupational health records, to the extent required or permitted by law.*

Patient (or Parent/Guardian/Authorized Representative) Signature: _____ Date: _____

Name of Parent, Guardian or Authorized Representative: _____ Date: _____

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

All sections below are for official use only:

Vaccine Administration Information for Immunizer:

Administration date: _____ Administration time: _____

CVX (Product): _____

Dose number: _____

IIS Recipient ID: _____

IIS vaccination event ID: _____

Lot number: _____

Unit of Use MVX (Manufacturer): _____

Sending organization: _____

Vaccine administering provider suffix: _____

Vaccine administering site on the body: Left deltoid ☐ Right deltoid ☐ Other ☐ (indicate location) _____

Vaccine expiration date: _____

Vaccine route of administration: _____

Vaccination series complete (date): _____

Fact Sheet for Vaccine Recipients and Caregivers version date: _____

IMPORTANT NOTE TO FACILITY: INSERT MOST RECENT PREVACCINATION CHECK LIST QUESTIONS FOR PATIENTS HERE: https://www.cdc.gov/vaccines/covid-19/downloads/pre-vaccination-screening-form.pdf