Streamlined Registration form for Tri-Cities Community Health

Patient/Employee Name (Last, First):		Date of Birth (mm/dd/yyyy):	
Address:	City:	State:	Zip Code:
Phone Number:		Gender Identity: (Male, Female, Trans M/F, Non Binary Other)	
Race: American Indian or Alaska Native, Asian, Black, Other Pacific Islander, White or Other **Ethnicity:** Hispanic or Latino Not Hispanic or Latino		Language: **Spanish** **English** **Other** **Homeless status:** Doubling Up Homeless Supportive Housing Street Transitional Other Unknown	
Marital status: **Public Housing**: (Yes / No) – Patient Declined		**Farmworker:** (Yes/ No) **Migrant** **or** **Seasonal**	

ACKNOWLEDGEMENT AND AUTHORIZATION:

I have read and understand the HIPAA/Privacy Policy for TRI-CITIES COMMUNITY HEALTH

Signed_____ **Date:** _____

I hereby assign my insurance benefits to be paid directly to the healthcare provider and authorize TRI-CITIES COMMUNITY HEALTH to release medical information required to process my claim. I have read and understand the Financial Policy for TRI-CITIES COMMUNITY HEALTH.

Signed_____ **Date:** _____

Medical Insurance:

Name_____

Identification number_____

Secondary Medical Insurance _____

Tri-Cities Community Health

COVID-19 Vaccine Acknowledgment

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

Phone: _____ Mobile Phone: _____Email: _____

Address: _____ City, State, Zip Code: _____

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 that the Moderna, Johnson and Johnson and Pfizer for ages 12-15 vaccines are approved under the FDA Emergency Use Authorization (EUA). Pfizer for ages 16 and older is fully approved by the FDA. 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 severe allergic reaction, (e.g. anaphylaxis), I must stay for 30 minutes. If I do not have a history of severe allergic reaction, 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 I must complete the series, and it I have been advised if there are two doses needed. 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.*

Disclosure of Records: *I understand the organization providing my vaccine may be required to or may voluntarily disclose my vaccine-related health information to 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-Cities Community Health, I understand that it will keep records of this vaccination for me in WAIIS and may keep my vaccination records in Tri-Cities Community Health employee occupational health records, to the extent required or permitted by law.*

Signature: _____ Date: _____

Parent or Guardian Signature_____Date:_____

All sections below are for official use only:

Vaccine Administration Information for Immunizer:

Administration date: _____ Administration time: _____ Location:_____

Manufacturer (please circle): Moderna, Pfizer, Johnson and Johnson

Dose number: 1st_____2nd:_____ 3rd_____

Lot number: _____

Dose (please circle one):0.5 mL or 0.3 mL

Administering site on the body: Left deltoid □ Right deltoid □ Other □ (indicate location) _____

Vaccine expiration date: _____

Vaccine route of administration: _____IM_____

Fact Sheet for Vaccine Recipients and Caregivers version date (please circle one):

Pfizer 8/23/2021 Moderna 8/12/2021 Johnson and Johnson 7/8/2021

Vaccinator Signature:_____ Vaccinator Name_____

TCCH Immunization Screening and Acknowledgement

Specific to COVID19 Vaccines, authorized under an Emergency Use Authorization

Name (Last, First): _____ DOB: _____

Phone: _____ Home Address: _____

Organization and Location: _____ Email _____

Please answer all the following screening questions:	Yes	No	Observation Period
Do you have a severe allergic reaction (anaphylaxis) to any component of a COVID-19 vaccine? *If yes, do not vaccinate.*			N/A
Are you under the age of 18? *If yes, do not vaccinate*.			N/A
Do you have a history of severe allergic reaction (anaphylaxis) to another vaccine or injectable medicine? *If yes, doctor's note required.*			Provider note required
Dy you have a history of severe allergic reaction (anaphylaxis) due to any other cause (not vaccines or injectable medicine)? *If yes, ok to vaccinate*			30 minutes
Do you have mild to moderate allergies (not anaphylaxis) to food, pets, environmental, latex or other allergies not related to vaccines ore injectable therapies? *If yes, ok to vaccinate.*			15 minutes
Do you currently have symptoms of COVID19 (fever, cough, shortness of breath) or other moderate to severe illness? Delay vaccination.			N/A
Have you received antibodies or plasma as part of COVID19 treatment in the past 90 days? *If yes, delay vaccination*			N/A
Have you received any other vaccinations for COVID19? If yes, when and what type. *If one dose of the Moderna vaccination and this would be the second dose, vaccinate. If one dose of the Pfizer vaccination then advise to seek second dose of Pfizer vaccine, don't vaccinate with Moderna. If one dose of J&J vaccine, don't vaccinate. If two doses of Moderna or Pfizer vaccine, don't vaccinate unless falls into special category that is recommended for third dose.*			N/A
Do you have one of the following conditions: 1. Been receiving active cancer treatment for tumors or cancers of the blood 2. Received an organ transplant and are taking medicine to suppress the immune system 3. Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system 4. Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome) 5. Advanced or untreated HIV infection 6. Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response *If first or second dose, vaccinate. If third dose, need provider note with recommendation for third dose.*			Provider note required to authorize third dose
Have you been given a copy of the Emergency Use Authorization Fact Sheet?			N/A
Have you received information about VSafe?			N/A

Updated: 08-17-21