SARS-CoV-2 (COVID-19) Vaccine Consent Form

Patient First Name: _____ **Patient Last Name**: _____ **Date of Birth**:_____

Gender: _____ **Phone**: _____ **Mother's First Name**: _____

Address/Location:_____ **City**: _____ **Zip**: _____

Medical Payment Resource: ☐ No Health Insurance ☐ HealthPAC ☐ Medi-Cal (Alameda Alliance)
☐ Medi-Cal (Blue Cross) ☐ Medi-Cal Fee For Service ☐ Medicare ☐ Medi-Medi ☐ Private (VA, Kaiser)
☐ Other insurance not listed: _____

Race (choose all that apply): ☐ American Indian or Alaskan Native ☐ Asian ☐ Latin-x
☐ Black/African American ☐ White/Caucasian ☐ Pacific Islander ☐ Race not listed: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Have you received a dose of the COVID-19 vaccine in the past? ☐ No ☐ Yes ☐ Not sure

Staff ONLY: If yes, provide date: _____ location:_____ **MFG: _____** **Staff Initial:**

VACCINE SCREENING QUESTIONS:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider/staff to explain it.

1. Are you feeling sick today?	☐ YES	☐ NO
2. Have you ever required an EpiPen®/epinephrine or needed to go to a hospital for a severe allergic reaction after receiving a vaccine in the past?	☐ YES	☐ NO
3. Have you had an immediate allergic reaction of any severity to a previous dose of a COVID-19 vaccine or any of its components (including polyethylene glycol [PEG])?	☐ YES	☐ NO
4. Have you had an immediate allergic reaction of any severity to polysorbate (due to potential cross-reactive hypersensitivity with the vaccine ingredient PEG)?	☐ YES	☐ NO
5. Have you received another vaccine in the last 14 days?	☐ YES	☐ NO
6. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐ YES	☐ NO
7. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐ YES	☐ NO
8. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐ YES	☐ NO
9. Do you have a bleeding disorder or are you taking a blood thinner?	☐ YES	☐ NO
10. Are you pregnant or breastfeeding?	☐ YES	☐ NO

VACCINE ADMINISTRATION CONSENT SIGNATURE:

I received a copy of the COVID-19 Vaccine Fact Sheet. I read it or had it explained to me. I had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and the risks of the vaccine and request that the vaccine indicated be given to me or to the person named on the registration form for which I am authorized to make this request.

Authorized Signature: _____ Date: _____

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FOR STAFF USE ONLY

Vaccine type: COVID-19 Vaccine Dose:_____ MFG: _____ Lot #: _____

Expiration Date: _____ Injection Site:_____ Clinic/Site Name and City_____

Immunizer Credential: RN LVN PA NP Paramedic MD PharmD

Immunizer Name: _____Signature: _____DATE:_____

Reviewer/Immunizer Notes:

Alameda County
Health Care for the Homeless

ALAMEDA COUNTY HEALTH CARE FOR THE HOMELESS
1404 Franklin Street, Suite 200, Oakland, CA 94612
TEL (510) 891-8950
FAX (510) 832-2139
www.achch.org

PATIENT CONSENT FORM

CONSENT FOR TREATMENT

I hereby give my voluntarily consent to receive health care services from Alameda County Health Care for the Homeless (ACHCH) program. I further authorize any health professional working for ACHCH program to provide medical/psychiatric diagnostic assessments, tests, procedures, and treatments that are necessary or advisable for the medical/psychiatric evaluation and management of my health care.

INSURANCE AND FINANCIAL INFORMATION

I am aware of the sliding scale fee discount policy of ACHCH program. I will not be denied any health or social services provided by ACHCH program because of inability to pay. ACHCH program is permitted to seek reimbursement from third party payment sources including HMOs, Medi-Cal, Medicare, and the Health Program of Alameda County (HealthPAC).

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of ACHCH program's Notice of Privacy Practices, which explains how my treatment records and personal information are kept confidential, may be used and disclosed by ACHCH program, and how I may access this information.

My signature below gives my consent to voluntary health care services from ACHCH program. If I am the patient's legal representative, my signature gives that consent. My signature also means that the information described above was discussed with me in a language or way that I understood and that I was given copies of these materials. Further, I understand that my consent will remain fully effective until it is revoked in writing and that I have the right to discontinue services at any time.

Patient Name (Printed):	
Signature of Patient:	**Date:**
Witness (Signature):	**Date:**

Immunization Registry Notice to Patients and Parents

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It's especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an immunization registry to keep track of shots and TB tests. If you change doctors, your new doctor can use the registry to see the shot/TB test record. It's your right to limit who is able to access your records in the California Immunization Registry (CAIR).

How Does a Registry Help You?

- Keeps track of all shots and TB tests (skin tests/chest x-rays), so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot/TB record from the doctor
- Can show proof about shots/TB tests needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots/TB tests are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots/TB tests children need
- Make sure children meet requirements for shots and TB tests needed to start child care or school

What Information Can Be Shared in a Registry?

- patient's name, sex, and birth date
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots/TB tests or medical exemptions

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number. Health officials can also look at the registry to protect public health.

Patient and Parent Rights

It's your legal right to ask your provider:

- to prevent other providers and schools from accessing your (or your child's) registry records
- not to send shot appointment reminders
- for a copy of your or your child's shot/TB test records
- who has seen the records and to change any mistakes

No action is needed to be part of CAIR. Other CAIR providers, schools, and health officials automatically have access to your or your child's records.

If you want to limit who sees your or your child's records:

1. Check with your provider to see if they can lock your records in CAIR
2. If your provider can't, complete a Request to Lock My CAIR Record form at **CAIRweb.org/cair-forms.**
3. If you change your mind, complete the Request to Unlock My CAIR Record form.
4. Fax printed forms to 1-888-436-8320, or email them to **CAIRHelpDesk@cdph.ca.gov.**

For more information, contact the CAIR Help Desk at 800-578-7889 or **CAIRHelpDesk@cdph.ca.gov**