## Vaccine Informed/Intake Consent Form

Our intake forms can be used for COVID Vaccine Informed/Intake Consent Form the COVID vaccine (ONLY) or for For a more customized other vaccinations. With RX Number form, imprint is available Clinic Information in the upper right hand multiple questions, it will corner for logos, Clinic ID/Store # help screen the health doctor/facility name Immunization S Date of Birth **Patient Information** and phone numbers. 4. Have you had a s of the patient and obtain Do you take antic blood thinner. Address
We will send vaccine information from this visit to your Primary Care Provider using the information pri Custom forms can also be quoted. Do you have a loi asthma, kidney d up-to-date information Do you have cand disease or any ot If you are part of a Senior Facility clinic, are you a resident  $\bigcirc$  or an employee/staff  $\bigcirc$ ? before seeing the doctor. Is this the patient's first  $\bigcirc$  or second  $\bigcirc$  dose of the COVID-19 vaccination? Do you have a we Insurance Information (for onsite clinics, please ensure a copy of the patient's insurance card(s) wi During the past y given immune (g. Vaccine Informed/Intake Consent Form 10. For women, are next month? Insurance Information O Yes O No
Prescription Insurance:

Are you the Primary Cardholder? RX Group ID Clinic Information Cardholder ID # Clinic ID/Store # Medicare Fields: ○ Yes ○ No

Is the Patient age 65 or older or Medicare Eligible? Last Name O Yes O NO

Are you the Primary Cardholder?

Cardholder?

O NO

If No, include the Primary Cardholder's DOB Patient Information Immunization S For chickenpox, Only answer these T uninsured, you must check the box below to attest that the following information is true and accurate:

○ I do not have any insurance, including but not limited to Medicare, bedicald or any other private or government-funded health benefit plan. Address
We will send vectore information from this visit to your frimary care frevoider using the information. Medical Insurance Carrier health benefit plan.

In order to have your vaccine administration fee paid for by the United States Health Resources & Services

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12. To you have a hist

13. Tyou are part of a Senior Facility clinic, are you a resident Vaccine Administra 11. Have you received if yes, please list: Insurance Information (For onsite clinics, please ensure a copy of the Administration Date 000 Prescription Insurance: Yes No
Are you the Primary Cardholder? Administering Immuni

1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19? 13. Do you have a hist To be filled out by State of NJ only.

1. In the past two weeks, have you had contact with anyone who tested positive for COVID-19?

2. In the past two weeks, have you had contact with anyone who tested positive for COVID-19? 14. Have you consume 15. Have you taken an 3. Have you had the new onset of fever, chills, cough, shortness of breath, difficulty or breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea? CONSENT FOR SERVICES: Information Sheet(s) or patie that I am receiving. I have ream to receive. I have had the my satisfaction. I understand voluntarily assume full respon voluntarily assume that I should remy. throat, nausea, vomiting, or diarrhea?

To be filled out by the immunizer: Patient Temperature:

Date: To be niled out by the immunizer: Patient Temperature:

If patient answers yes to any of these questions or patient's bodily rempenture is 100° F or greater, please inform them that they should not receive the vaccine at this time, instruct them to contact their primary care provider for the next steps and that the facility coordinator will be notified. Medicare Fields: O Yes O No
Is the Patient age 65 or older or Medicare Eligible? State of NJ only. YES NO KNOW Prescriber Name Medical Insurance: 000 MS:Select all fields
OK:Select Race an Cardholder ID # Immunization Screening Questions exam within the passion of that would mean I should not authorization to REQU clinic to release information a limit to release information a Are you sick today? (For example: a cold, fever or acute lilness) 000 2. Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) (rur example; eggs, gelatin, neomycin, mimerosal, etc.)

3. Have you ever had a serious reaction after receiving a vaccination (including fainting or feeling distry)? Has any physician or other healthcare professional ever cautioned or verification of the professional ever cautioned or verification of the professional ever cautions or receiving vaccines outside of verification of the professional every example Ethnicity: 1 - Hisp I do not have any insurance health benefit plan. Vaccine Administra or State Identification Number & Sta Name Administration Date Immunization Screening Questions Are you sick today? (For example: a cold, fever or acute illness) Registry Sharing Indicator 

Yes 

No Do you have allergies or reactions to any foods, medications, vaccin (For example: eggs, gelatin, neomycin, thimerosal, etc.) 3. Have you ever had a serious reaction after receiving a vaccination (for teeling dizzy)? Has any physician or other healthcare professional warned you about receiving certain vaccines or receiving vaccines of a medical setting? Administering Immunize To be filled out by ii 2. State of NJ only. Have you had a seizure or a brain or other nervous system problem or Guillain Barre. Prescriber Name Intake forms play a critical role in the clinics Do you take anticoagulation medication? For example: Warfarin, Coumadin or other blood thinner. MS:Select all fields

OK:Select Race and Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder? operational and financial success. Faster 7. For women, are you pregnant or is there a chance you could become pregnant during the next month? services means shorter wait times and 000 happier patients. Increase efficiency by screening patients and get up-to-date information on new and Registry Sharing Indicator ( ) Yes ( ) No returning patients 96% of patient complaints cite poor Small quantities and communications, disorganization and excessive large runs offered delays in seeing a physician as the cause Stock, imprint or custom for dissatisfaction

COVID questionnaire or general

vaccination questionnaire

Get the patients consent on paper