OLYMPIC MEDICAL CENTER

939 Caroline St.
Port Angeles, WA 98362
(360) 417-7000
Clallam County Public Hospital District #2

COVID-19 Vaccine Consent Form

OMC37060
Last Revision: 8/17/2021

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

Phone Number:_____ Gender: ❑ Male ❑ Female ❑ Non-Binary ❑ Unspecified / Indeterminate

Address:_____ City: _____ State:_____ Zip:_____

Ethnicity: ❑ Hispanic ❑ Not-Hispanic A person not of Spanish culture or origin

Race: ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander
❑ White/Caucasian ❑ Other:_____

Primary Insurance:_____ Subscriber ID:_____ Group #:_____

Subscriber Name:_____ Date of Birth_____ Relationship:_____

Address:_____ City: _____ State:_____ Zip:_____

1. Are you feeling sick today? (For example, a cold or a fever or a new illness)	❑ Yes ❑ No
2. Have you ever received a COVID-19 vaccine? If yes, which vaccine product did you receive? ❑ Moderna ❑ Pfizer ❑ Janssen (Johnson & Johnson) Other:_____ Did you bring your vaccination card or documentation?	❑ Yes ❑ No ❑ Yes ❑ No
3. Have you ever had a **SEVERE allergic** reaction to a component of a COVID-19 vaccine. *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)* • Polyethylene glycol (PEG) found in some medications such as laxatives and colonoscopy preparations. • Polysorbate which is found in some vaccines, film coated tablets and intravenous sterioids. • A previous dose of COVID-19 vaccine.	❑ Yes ❑ No
4. Have you ever had a **SEVERE allergic** reaction to anything else. (Medication, environment, food, etc.) *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)*	❑ Yes ❑ No
5. Check all that apply to you:	
Am a female between ages 18 and 49 years old	❑
Am a male between ages 12 and 29 years old	❑
Have a history or myocarditis or pericarditis	❑
Treated with **passive antibody therapy** (monoclonal antibodies or convalescent serum) for COVID-19	❑
Diagnosed with **Mulitsystem Inflammatory Syndrome** (MIS-C or MIS-A) after a COVID-19 infection	❑
Have a **weakened immune system** caused by something such as **HIV infection or cancer** or do you take **immunosuppressive drugs or therapies**	❑
Do you have a **bleeding disorder** or are you taking a **blood thinner**	❑
Have a history of **heparin-induced thrombocytopenia (HIT)**	❑
Am currently pregnant or breastfeeding	❑
Have received **dermal fillers** (typically located in the face or lips)	❑
Have a history of Guillan-Barré Syndrome	❑

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OFFICE USE ONLY	❑ 1st Dose ❑ 2nd Dose ❑ 3rd Dose	**Date:**_____
EPIC Label or Patient Name:_____ Date of Birth:_____	**COVID-19 Vaccine IM Deltoid:** ❑ Lt ❑ Rt Dose:_____ Lot#:_____ NDC#:_____ Expiration:_____ **(Labels available with vaccine.)**	**Time:**_____ **Observation Time: 15 30 minutes** **Administered By Signature:**_____

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.
  For additional information go to: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/about-vaccines/index.html

- 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 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 get two doses of the COVID-19 vaccine and receive the same vaccine each time. 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. 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.

Acknowledgements:

_____ **by initialing you agree that you have read the acknowledgements and agree to their terms**

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 Olympic Medical Center I understand that it will keep records of this vaccination for me in EPIC and may keep my vaccination records in Olympic Medical Center's employee occupational health records, to the extent required or permitted by law.

Signature of Patient or Patient's Authorized Representative:_____ **Date:**_____

Printed Name:_____