Visit Healthcare Administration Record and Informed Consent Event ID _____

First Name: _____ **Last Name**: _____ **DOB**: _____ **Age:** _____ **Gender**: ____

Home Address: _____**City**: _____ **State**: ___ **Zip**: _____

Phone Number: _____ **Email:** _____ **Child's Weight** _____

Race: American Indian/Alaskan Native ____ Asian ____ Black/African American ____

White ____ Native Hawaiian/Other Pacific Islander ____ Other ____ Decline to State ____

Ethnicity: Hispanic/Latino ___ Not Hispanic/Latino ___ Decline to State ___

Primary Language: _____

Questions:

1. Is this a third dose booster? Yes ___ No ___
2. Have you ever had a positive Covid test? Yes ___ No ___
3. Is the person to be vaccinated sick or injured today? Yes ___ No ___
4. Do you identify as having a disability? Yes ___ No ___
5. Does the person to be vaccinated have allergies to medications, food components, vaccine components, or latex? If yes, please list. Yes ___ No ___
   Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, thimerosal
6. Has the person to be vaccinated ever had a reaction, fainted, or felt dizzy after receiving a vaccine or has any physician or other healthcare professional ever cautioned or warned them about receiving certain vaccines or receiving vaccines outside of a medical setting? Yes __ No ___
7. Is the person to be vaccinated currently pregnant, considering becoming pregnant in the next month, or breast-feeding? Yes ___ No ___
8. Does the person to be vaccinated have a weakened immune system, is in contact with anyone with a severely weakened immune system or in long-term treatment with drugs such as high-dose steroids? Yes ___ No ___
   Examples: cancer, leukemia, lymphoma, HIV/AIDS, transplant, rheumatoid arthritis, Ankylosing spondylitis, Chrohn's disease or any other immune system disorder?
9. Has the person to be vaccinated received any vaccinations or skin tests in the past four weeks? *Examples: Flu, Shingles* Yes ___ No ___
10. Is the person to be vaccinated currently on home infusions, weekly injections, (such as Remicade, Humira, Enbrel, Cimzia, Simponi, Simponi Aria, Xeljanz, Orencia, Arava, Actermra, Cyotaxan, Rituxan, adalimumab, infliximab or entanercept), high dose methrotrexate, azathioprine, mercaptopurine, anticancer drugs, antivirals or radiation treatment, cortisone or high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks? Yes ___ No ___
11. Has the person to be vaccinated received antibodies, a transfusion of blood or blood products, been given immune (gamma) globulin, or antivirals in the past year? Yes ___ No ____
12. Does the person to be vaccinated have a history of thrombocytopenia? Yes ___ No ____

13. Has the person to be vaccinated had a history of Immune Mediated Thrombotic Purpura (iTTP) within the last 90 days? Yes ___ No ___

Please read the section below carefully and sign and date acknowledging that you agree:

I hereby give my consent to Visit Healthcare to administer the COVID-19 vaccine I have requested. I understand the risks of receiving this medication and have received, read and/or had explained to me the Vaccine Information Statement and/or Vaccine Patient Face Sheet for the vaccine I have elected to receive. I acknowledge that I have had a chance to ask questions and that any questions were answered to my satisfaction. I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering healthcare provider. On behalf of myself, my heirs, and personal representatives, I fully release and discharge Visit Healthcare, its staff, successor, division, affiliates, officers, directors, contractors, and employees from any and all liabilities or claims whether known or unknown arising in any way related to the administration of the vaccine listed above. Initials: _____

I understand, acknowledge, and consent that the administration of this vaccine will be entered into my state's immunization registry. I understand the purposes/benefits of my state's immunization registry and acknowledge that, depending upon my state law, I may prevent disclosure of my immunization to the state registry with a signed Opt-Out. The provider has informed me that I may have the right to refuse. I acknowledge that the administration of this vaccine will be reported to any required local, state, or federal health authorities. Initials: _____

I, _____ give consent to have my child, _____ vaccinated and/or in my absence.

Signature: _____

Date: _____

Date of vaccination: _____ Intake Initials _____

Name of patient: _____ Patient Room _____

Vaccine received: Pfizer ____ Moderna ___ J&J ___

Date of Vac 1 _____ Date of Vac 2 _____ Date of Vac 3 _____

Lot Number: _____ Expiration Date: _____

Location of vaccine: Left Arm ___ Right Arm ___ Other _____

Initials of Vaccinator: _____ ***To be completed by VISIT Healthcare employee only*

MCIR _____

Visit Data _____

Demographic _____