VACCINE ADMINISTRATION FORM

GATEWAY COMMUNITY Health Center, Inc.

SECTION 1 – INFORMATION ABOUT THE PERSON RECEIVING THE VACCINE

Everything in this section is required.

Name: _____ Date of Birth: _____/_____/_____ Age: _____ Phone: (_____)_____

Address: _____ City: _____ County: _____, TX Zip Code: _____

Have you ever received a COVID-19 vaccine? ☐Yes ☐No If yes, manufacturer name: _____ Date received: _____

Insurance Carrier Name: _____ ID #: _____ Group #: _____

Policy Holder Name (if different): _____ Policy Holder Date of Birth: _____

Social Security Number: _____-_____-_____ (this is needed by the federal government if you do not have health insurance)

☐ I do not have medical insurance

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Prefer not to disclose

Gender: ☐ Male ☐ Female ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Prefer not to disclose

Please check all that apply: ☐Migratory/Seasonal Worker ☐Homeless Status ☐Veteran ☐Public Housing

Gateway may contact your primary care provider informing them of vaccine(s) given today using the information provided below

Primary Care Provider Name: _____Phone: (_____)_____Fax: (_____)_____

SECTION 2A – QUESTIONS TO DETERMINE VACCINE ELIGIBILITY (circle YES or NO)

This section is required.

1. Do you currently have COVID-19 or have you received monoclonal antibodies or plasma infusion in last 90 days?	☐YES ☐NO
2. Are you sick today or do you have any of these symptoms: fever, chills, shortness of breath, body aches, loss of taste/smell	☐YES ☐NO
3. Have you ever had an anaphylactic reaction, serious allergic reaction, or any other serious reaction to a vaccine?	☐YES ☐NO

SECTION 2B – CLINICAL CONSIDERATIONS (circle YES or NO)

This section is required.

4. Are you pregnant or breastfeeding?	☐YES ☐NO
5. Are you immunocompromised or taking medications that affect your immune system?	☐YES ☐NO
6. Are you taking blood-thinning medications or do you have a bleeding disorder?	☐YES ☐NO
7. Do you have a history of myocarditis or pericarditis?	☐YES ☐NO
8. Do you have a history of Guillain-Barré Syndrome (GBS)?	☐YES ☐NO

SECTION 3 – PLEASE READ CAREFULLY AND ACKNOWLEDGE WHERE APPROPRIATE

This section is required.

I hereby give my consent to the Gateway Community Health Center, Inc. ("Center") to administer the vaccine(s) (the "Services") I have requested below. Section Date: August 2021

With my initials, I certify that:

_____I am: (i) the Patient and at least 18 years of age; (ii) the parent or guardian of the minor Patient; or (iii) the legal guardian of the Patient; or (iv) a person authorized under the law of another state or a court order to consent for the child; OR

_____The persons identified under (ii), (iii), or (iv), in the preceding sentence are unavailable and I have authority to consent to the immunization of the child because I am a (i) grandparent; (ii) adult brother or sister; (iii) adult aunt or uncle; (iv) stepparent; or (v) another adult who has actual care, control, and possession of the child and has written authorization to consent for the child from a parent, managing conservator, guardian, or other person who, under the law of another state or a court order, may consent for the child; additionally, I certify that I do not have knowledge of any express refusals or withdrawn authorizations of consent and have not been told not to give consent for the child.

I understand that any Protected Health Information ("PHI") I provide Center will only be used or disclosed by Center in accordance with Center's Health Insurance Portability and Accountability Act ("HIPAA") Notice of Privacy Practices. By signing below I acknowledge receipt of such HIPAA Notices of Privacy Practices and consent to the uses and disclosures of PHI described therein. While Center reserves the right to not do so, I consent to Center reporting my immunization information to the State Immunization Registry. Should Center elect to report my immunization history to the Texas central immunization registry, ImmTrac, I further understand that my immunization information may be accessed by other health care providers, educators, public health representatives, state agencies and certain insurance payers. I further authorize Center to (1) release my medical or other information to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment or otherwise, (2) submit a claim to my insurer for the below requested items and services, and (3) request payment of authorized benefits be made on my behalf to Center with respect to the below requested items and services.

NOT A SUBSTITUTE FOR A PHYSICIAN

I agree to consult a physician if I require medical advice or services at any time.

RELEASE, IMDEMNITY AND DISCLAIMER

I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s), including novel COVID-19 vaccine(s). I understand the risks and benefits associated with vaccine(s) and elect to vaccine(s). I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I additionally acknowledge that I have received a copy of the Center notice of privacy. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care provider. I understand that in the course of the requested vaccine administration, a Center representative could possibly be exposed to my blood or bodily fluids. In such event, I agree to review and execute the "Center Post-exposure Consent for Testing" form.

On behalf of myself, my heirs and personal representatives, I further hereby WAIVE, RELEASE, and AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS (including for costs and attorney's fees) Center, its staff, agents, employees and corporate affiliates from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of vaccine(s) and related services, even should such damages or losses result from Center's negligence.

I have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet or the Vaccination Information Statement for the vaccine I have elected to receive.

Name of person giving consent, if different from patient: _____ **Relationship to patient**: _____

Patient Signature: _____ **Date:** _____

(Parent or Legal Guardian, if minor)

SECTION 4 – MEDICARE PART B USE ONLY

This section is required for Medicare recipients only.

Medicare Part B Authorization Form

Statement to Permit Assignment of Medicare Benefits

- I understand that I am giving **Center** permission to ask for Medicare payments for my medical care, including supplies and equipment.
- I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests.
- I understand that the Centers for Medicare & Medicaid Services (CMS) is the government's Medicare agency. I understand that a photocopy of this release is as valid as the original document. Furthermore, I understand that I am responsible for paying any deductible or coinsurance amounts.
- Therefore, I ask that payment of authorized Medicare benefits be made to either me or on my behalf to Center for any services or items furnished to me by **Center**. I authorize any holder of medical or other information about me to release such information to the Centers for Medicare & Medicaid Services (CMS) and its agents as needed to determine these benefits or benefits for related services.

Name: _____ HICN: _____

Signature: _____ Date: _____

SECTION 5 – CENTER USE ONLY

Temperature checked by (Employee initials):

Vaccine	Amount Administered	Manufacturer	Dose # (circle)	Route	Lot Number Expiration Date	Site of Administration*	Reviewed Vaccine Complete (initial)
COVID-19 vaccine	0.5 ml	Moderna	1 or 2 or 3	IM		☐ RD LD ☐	Initial here
COVID-19 vaccine	0.5 ml	Janssen	1	IM		☐ RD LD ☐	Initial here
COVID-19 vaccine	0.3 ml	Pfizer	1 or 2 or 3	IM		☐ RD LD ☐	Initial here

* RD - Right Deltoid, LD - Left Deltoid, RA - Right Arm, LA - Left Arm

Vaccine Information

Pfizer – 2 shot series at 0 and 21 days, authorized for 12 years and older with parent/guardian consent, if a minor. Third dose authorized for immunocompromised.
Moderna – 2 shot series at 0 and 28 days, authorized for 18 years of age and older and third dose authorized for immunocompromised.
Janssen – 1 shot authorized for 18 years of age and older.

To Be Completed by Center

Employee Name: _____

Signature: _____

Clinic Location: _____

Date of Immunization: _____ **Next Dose Due Date:** _____