Inactive Vaccine Consent and Administration Record

Patient Information:
Last Name: ________________________ First Name: __________________________ Date of Birth: __________
Address: ___________________________ City, State, Zip: ______________________ Phone: ________________
Primary Care Provider (PCP) Name: ______________________________________ PCP Phone: ________________
PCP Address: ________________________ City, State, Zip: ______________________

Screening Questions:

	Yes	No	Unsure
1. In the past 14 days, have you tested positive for COVID-19 or are you currently advised to quarantine?*	☐	☐	☐
2. In the past 2 weeks, have you had contact with anyone who tested positive for COVID-19?*	☐	☐	☐
3. Have you recently had new onset of cough, shortness of breath or difficulty breathing, fever, chills, loss of taste or smell, or sore throat?*	☐	☐	☐
*For any yes answers to the above questions or a body temperature over 100° F, immunizer should consult with medical director or primary care provider prior to administering.			
4. Are you sick today? (For example: a cold, fever or acute illness)	☐	☐	☐
5. Have you ever had a severe (life-threatening) reaction to food, pets, venom, environmental agents, latex, or oral medications?	☐	☐	☐
6. Have you had Guillain-Barre Syndrome? If yes, was it associated with a vaccine?	☐	☐	☐
7. Have you ever had a serious reaction to a vaccine or other injectable therapy in the past?	☐	☐	☐
8. Have you had any vaccines in the last 2 weeks?	☐	☐	☐
9. For women: Are you currently pregnant?	☐	☐	☐
10. Do you have any disease or condition that weakens your immune system OR are you taking medications that may weaken your immune system (prednisone, steroids, anticancer drugs)?	☐	☐	☐

Consent for Services: I have been provided with the Vaccine Information Sheet(s) corresponding to the vaccine(s) that I am receiving. I have read or have had explained to me the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.
Authorization to Request Payment: I do hereby authorize Chestnut Health Systems, Inc. ("Chestnut") to release information and request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid 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 that Chestnut may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at Chestnut (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that Chestnut will use and disclose my health information as set forth in Chestnut Health Systems' Notice of Privacy Practices (copy is available online or by requesting a paper copy).
x ____ Date: _________________________
Signature of patient to receive vaccine or person authorized to make the request (parent/guardian)

Vaccine Administration Information:
Administration Date: _____________ Vaccine: _________________ Manufacturer: ______________________ Lot #: ___________ Exp. Date: ___________
Volume (mL): ____________ Injection Site: Left / Right Deltoid IM (*circle one*)

Administering Immunizer Name and Title: ____
Administering Immunizer Signature: ____

Revised 2/4/2021