|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PATIENT INFORMATION (Please Print) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s Last name: | | | | | First: | | | | | | | | | | | | | Middle: | | Hispanic or Latino? Yes/No | | | | | | | Race (Please List) | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| Maiden Name: | | | Primary Phone: | | | | | | | | | | | | | | | | | Birth Date: | | | | | | | | | | Age: | | | Sex: | | | | County: | |
|  | | | ( ) | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | ❑ F  ❑ M | | | |  | |
| Street Address: | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | State | | | | | | Zip Code | | |
|  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | |  | | |
| Email Address: | | | | | | | | | | | | | | | | | | | | Primary Care Physician | | | | | | | | | | | Physician Phone Number | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Guarantor INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Parent/Guardian: | | | | | | | | Birth Date: | | | | | | Primary Phone: | | | | | | | | | | Email Address: | | | | | | | | | | | | | | |
|  | | | | | | | | / / | | | | | | ( ) | | | | | | | | | |  | | | | | | | | | | | | | | |
| Address (if different): | | | | | | | City: | | | | | | | | | | | | | | | | State: | | | | | | | | | ZIP Code: | | | | | | |
|  | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is this patient covered by insurance? | | | ❑ Yes | | | | | | | ❑ No | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please indicate primary insurance | | ❑ BCBS | | | | | | | | | ❑United Healthcare | | | | | | | | ❑ Sunflower | | | | | | | ❑ Cigna | | | ❑ Aetna | | | | | | | | | ❑ Medicare ❑Humana |
| Subscriber’s name: | | | | | | | | | | | | | | | Birth Date: | | | | | | | Policy Number: | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | / / | | | | | | |  | | | | | | | | | | | | | | | | |
| Patient’s relationship to subscriber: | | | | ❑ Self | | | | | | | | ❑ Spouse | | | | | ❑ Child | | | | | ❑ Other | | | | | |  | | | | | | | | | | |
| Name of secondary insurance (if applicable): | | | | | | | | | Subscriber’s name: | | | | | | | | | | | | | | | | | | | Group no.: | | | | | | | Policy no.: | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | |  | | | |
| Patient’s relationship to subscriber: | | | | | | ❑ Self | | | | | | ❑ Spouse | | | | | ❑ Child | | | | ❑ Other | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of local friend or relative (not living at same address): | | | | | | | | | | | | | | | | Relationship to patient: | | | | | | | | | Home phone no.: | | | | | | | | | Work phone no.: | | | | |
|  | | | | | | | | | | | | | | | |  | | | | | | | | | ( ) | | | | | | | | | ( ) | | | | |

**The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I also authorize SEKMCHD or insurance company to release any information required to process my claims.**

**Parent/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I declare that I or my child:**

1. Have not experienced anaphylaxis (difficulty breathing) or severe allergic reactions from a previous vaccination or an injectable medication.
2. Is not currently sick with a fever, active respiratory infection or other moderate/severe illness.
3. Has have not received monoclonal antibodies or convalescent plasma for treatment of COVID-19 within the past ninety (90) days.
4. Is not allergic to the ingredients in the COVID-19 vaccine.

I understand that if I have any of the above conditions, I could be at increased risk of having a negative reaction or problem from the vaccine.

**I further declare that if I have any of the following conditions, I have had the opportunity to speak with my primary care provider and am making an informed decision to receive the vaccine:**

1. Pregnant, attempting to become pregnant or breastfeeding;
2. Have a bleeding disorder or are on a blood thinner;
3. Are immunocompromised or are taking a medication that affects the immune system (such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn’s disease or psoriasis; HIV/AIDS, cancer, leukemia, ankylosing spondylitis or radiation treatments).

I agree to WAIT at the clinic location for 15 minutes after receiving the vaccine. If I have previously had a severe allergic reaction to a vaccine or injectable medication, I agree to WAIT at the clinic location for 30 minutes after receiving the vaccine.

I understand that the common risks associated with the COVID-19 vaccine include but are not limited to pain, redness or swelling at the site of injection, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, feeling unwell or swollen lymph nodes (lymphadenopathy). I understand that the vaccine may cause a severe allergic reaction which can include anaphylaxis (difficulty breathing, swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness). I understand that these may not be all the side effects of the COVID-19 vaccine as the vaccine is still being studied in clinical trials. I also understand that it is not possible to predict all possible side effects or complications which could be associated with the vaccine. I understand that the long-term side effects or complications of this vaccine are not known at this time.

I understand that the vaccination is being given by the SEK Multi-County Health Departments (SEKMCHD). The owner and/or operator of this site, their affiliates, officers, directors, employees and agents expressly disclaim any responsibility for the vaccination. My consent is given in light of this knowledge, and in consideration of (SEKMCHD) giving the COVID-19 vaccine. I, for myself and my heirs, administrators, trustees, executors, assigns and successors in interest do hereby agree to release and hold harmless the SEK Multi-County Health Departments, its subsidiaries, divisions, affiliates, successors, assigns, officers, trustees, employees, volunteers and agents from and against any and all demands, damages, losses, costs, expenses, obligations, liabilities, claims, actions and cause of action (whether any of which is groundless or otherwise) of any nature whatsoever (including, without limitation, reasonable attorney’s fees and court costs) by reason of or resulting, in any way, from any and all acts, accidents, events, occurrences, omissions and the like related to, or arising out of, directly or indirectly, my receipt of this COVID-19 vaccine. The SEK Multi-County Health Departments makes no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness for a particular purpose regarding the vaccine or its effectiveness.

I have read and understood the “Fact Sheet” by the FDA regarding the COVID-19 Vaccination. I further understand and agree that SEKMCHD is required to submit COVID-19 vaccine administration data to the Kansas Immunization Information System (KSWebIZ), and report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS).

I understand and agree to all of the above and I hereby give my consent to the staff of the SEK Multi-County Health Departments to give me a COVID-19 vaccine.

Signature: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_\_\_\_\_\_\_ COVID-19 Vaccine Lot # & Exp. Date | Dose \_\_\_\_\_\_\_\_  (circle one) | Route Intramuscular  (circle one) | Administered by  (signature, title, date) |
| Lot #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Exp. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1st Dose 2nd Dose  Extra Booster | RD LD  RVL LVL |  |
| \_\_\_\_\_\_\_\_\_ COVID-19 Vaccine Lot # & Exp. Date | Dose \_\_\_\_\_\_\_\_\_  (circle one) | Route Intramuscular  (circle one) | Administered by  (signature, title, date) |
| Lot #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Exp. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1st Dose 2nd Dose  Extra Booster | RD LD  RVL LVL |  |