Battle Mountain General Hospital
COVID - 19 Consent for Vaccination

## PATIENT INFORMATION

| Last Name | First Name | Middle Initial | Date of Birth | Gender |
|---|---|---|---|---|
| | | | | |

| Address | City/State/Zip code | Phone Number |
|---|---|---|
| | | |

Employer

Race: American Indian or Alaska Native O Asian O Native Hawaiian/Pacific Islander O
Black O White O Other Race O

Ethnicity: Hispanic O Not Hispanic or Latino O Unknown O

Is this your first O or second O dose of the COVID-19 vaccination:

## MEDICARE FIELDS

Yes O No O

Is the Patient age 65 or older or Medicare Eligible? Medicare Part A/B ID Number (MBI)

Note: MBI is required for all patients age 65 and older, or Medicare eligible.
Refer to your Medicare Red, White, and Blue Card

## MEDICAL INSURANCE

| Medicare Insurance Carrier | Cardholder ID # | Group ID | Payer ID |
|---|---|---|---|
| | | | |

| Primary Cardholder Name | Primary Card Holder DOB |
|---|---|
| | |

If uninsured, you must check the box below to attest that the following information is true and accurate:

O I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government-funded health benefit plan. In order to have your vaccination administration fee paid for by the United State Health Resources & Services Administration's COVID-19 Program for Uninsured Patients, please provide either (A)valid Social Security Number, (B) state identification number and state of issuance, Or (C) driver's license number and the state of issuance.

## COVID - 19 SCREENING QUESTIONS

| | Yes | No | Unknown |
|---|---|---|---|
| 1. Are you feeling sick today? | O | O | O |
| 2. Have you ever received a dose of COVID-19 vaccine? | O | O | O |
| 3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) in the past? For example, a reaction for which you were treated with epinephrine or EpiPen or for which you had to go to the hospital? | O | O | O |
| 4. Have you received any vaccine in the past 14 days? | O | O | O |
| 5. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days? | O | O | O |
| 6. Do you have a bleeding disorder or are you taking a blood thinner? | O | O | O |
| 7. For women, are you currently pregnant or breastfeeding? | O | O | O |

PATIENT NAME | Date of Birth

## UNDERLYING HEALTH CONDITIONS

Nevada is using CDC guidance to identify the specific underlying health conditions that cause a person to be at an increased risk of severe illness from COVID-19.

I have reviewed Department of Health and Human Services Technical Bulletin dated March 3, 2021 on the update to the Nevada State Immunization Program Guidance on Vaccine Access for Nevadans with Underlying Health Conditions.

I have the following underlying condition (s) :

***CONSENT FOR SERVICES*** : I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read 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 understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call the hospital, contact my doctor, call 911. 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 BMGH 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 that BMGH 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 BMGH (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 BMGH will use and disclose my health information as set forth in the BMGH Privacy

**X** _____ _____

Signature of patient to receive vaccine (or parent, guardian, or authorized representative ***If signing on behalf of the patient, you are stating that you are authorized to provide consents on behalf of the patient*** | Date

Name of parent, guardian, or authorized representative | Relationship | Phone Number

## VACCINE ADMINISTRATION INFORMATION

| | | | | |
|---|---|---|---|---|
| | COVID | | | |
| Administration Date | Vaccine | | VIS | Manufacturer |
| | | IM | | 0.5 mL |
| Lot # | Exp. Date | Route | Site | Volume (mL) |
| | | | | |

Administering Immunizer Name & Title | Administering Immunizer Signature