

Battle Mountain General Hospital
COVID - 19 Consent for Vaccination

PATIENT INFORMATION

Last Name	First Name	Middle Initial
Date of Birth	Gender	SSN
Address	City/State/Zip code	Phone #

Employer

Race:	American Indian or Alaska Native <input type="radio"/>	Asian <input type="radio"/>	Native Hawaiian/Pacific Islander <input type="radio"/>
	Black <input type="radio"/>	White <input type="radio"/>	Other Race <input type="radio"/>

Ethnicity:	Hispanic <input type="radio"/>	Not Hispanic or Latino <input type="radio"/>	Unknown <input type="radio"/>
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Is this your **first dose** or **second dose** or **_____ Booster** of the COVID-19 vaccination:
(3rd, 4th, or 5th)

MEDICARE FIELDS

Yes <input type="radio"/>	No <input type="radio"/>
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

Medical 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:

- 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Have you ever received a dose of COVID-19 vaccine?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Have you received any vaccine in the past 14 days?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Have you received monoclonal antibodies or convalescent plasma as part of a COVID-19 treatment in the past 90 days?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Do you have a bleeding disorder or are you taking a blood thinner?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. For women, are you currently pregnant or breastfeeding?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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 the most current Department of Health and Human Services Technical Bulletin 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

Lot # Exp. Date Route Site Volume (mL)

Administering Immunizer Name & Title

Administering Immunizer Signature