Northern Valley Indian Health
Your Health. Our Mission.

PATIENT CONSENT & RELEASE FORM AND SCREENING QUESTIONNAIRE FOR COVID-19 VACCINE

Patient's Full Name (First, MI, Last): _____

Date of Birth: _____Age: _____ Gender (circle one): Male / Female / Other_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Care Doctor: _____ Doctor's Number: _____

Emergency Contact Name and Number: _____

Emergency Contact Person's Relationship: _____

COVID-19 Dose		COVID-19 Vaccine Manufacturer			
☐	1st Dose	☐	Moderna	☐	AstraZeneca
☐	2nd Dose	☐	Pfizer	☐	Johnson & Johnson
		☐	Novavax	☐	Sanofi Pasteur
		☐	Other:		

Screening Questionnaire for Vaccination (if you answer yes, please explain below). Please circle:

1. Are you sick today? Yes No
2. Have you received any vaccinations in the past two weeks? Yes No
3. Have you received passive antibody therapy as treatment for COVID-19? Yes No
4. Have you ever received a dose of COVID-19 vaccine? Yes No
   If YES, which vaccine product?
   - ☐ Pfizer
   - ☐ Moderna
   - ☐ Johnson & Johnson
   - ☐ Another product _____
5. Have you ever had an allergic reaction to a previous dose of COVID-19 vaccine or components such as Polyethylene Glycol or Polysorbate? Yes No
6. Do you have allergies to medications, food, latex, or any vaccine components? Yes No
7. Have you ever had a serious reaction after receiving a vaccination or other injectable medication? Yes No

   - If YES to 5 above, was the serious allergic reaction after receiving a COVID-19 vaccine? Yes No

- If YES to 5 above, was the serious allergic reaction after receiving another vaccine or other injectable medication? Yes No

8. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? Yes No
9. Do you have a bleeding disorder or are you taking a blood thinner? Yes No
10. Do you have cancer, leukemia, AIDS, or any other immune system problem? Yes No
11. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? Yes No
12. Have you had a seizure or a brain or other nervous system problem? Yes No
13. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? Yes No
14. Do you have dermal fillers? Yes No
15. For women: Are you pregnant or is there a chance you could become pregnant during the next month? Yes No
16. For women: Are you breastfeeding? Yes No

Consent and Waiver: I consent the staff to administer the vaccination mentioned above. I have reviewed the vaccine information provided to me and understand the benefits and risks of receiving this vaccination and choose to assume this risk. I fully release and discharge the vaccination providers and Northern Valley Indian Health, its affiliations and their officers, and employees from any illness, injury, loss, or damage that may result therefrom. I assign payment of authorized insurance benefits due to me to be paid to the Northern Valley Indian Health. I consent to the release of medical information when necessary for billing, reimbursement, and medical protocol. I understand that Northern Valley Indian Health will report any vaccine medications I received to the appropriate state or federal Immunization Information System (IIS), Vaccine Administration Management System (VAMS) and/or other designated vaccine registry. I agree to wait near the vaccination area as designated by NVIH for approximately 15-30 minutes to receive care in case of adverse reaction.

I acknowledge that I have received a copy of the Notice of Privacy Policies of Northern Valley Indian Health. I understand the Notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed and of my rights with respect to my health information.

Signature of Patient: _____Date::_____

Print Patient Name:_____ DOB: _____