Harbor Beach Community Hospital
210 South First Street
Harbor Beach, MI 48441
(989) 479-3201 Fax (989) 479-5000

Identification Label

Vaccine Administration Record (VAR)
Informed Consent

Section A-1: (Please print clearly)

First Name: _____ Last Name: _____ Date of Birth: _____

I want to receive the following vaccination(s): COVID-19 Vaccination

Section A-2: I certify that I am (a) the patient and at least 18 years of age; (b) the legal guardian of the patient, or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or is unable to consent for themselves. Further, I hereby give my consent to Harbor Beach Community Hospital and the licensed healthcare professional administering the vaccine, as applicalbe (each an "applicable Provider") to administer the vaccine(s)) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risk and benefits associated with the above vaccine(s) and have received, read, and/or had explained to me the EUA Fact Sheet for patients and caregivers on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of the patient, the patient's heirs and personal representative, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above.

I acknowledge that (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities (Government Agencies") such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Center for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the Government Agencies, State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form.

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I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to go through the State HIE or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV), and mental health information, to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice. Harbor Beach Community Hospital may disclose your vaccination information from this visit for public health purposes and if you are an employee, will send your vaccination information to your employer as required.

_____
Printed Name

_____ _____
Patient/Authorized Person Signature Date

Patient Name _____ Date _____

Section B-1

Screening Questions: The following questions will help us determine your eligibility to be vaccinated today.

1. Do you feel sick today?	Yes □	No □	Don't Know □
2. Do you have any health conditions, such as heart disease, diabetes or asthma? If yes, please list: _____	Yes □	No □	Don't Know □
3. Do you have any allergies to latex, medications, food or vaccines (examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list: _____	Yes □	No □	Don't Know □
4. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	Yes □	No □	Don't Know □
5. Have you ever had a seizure disorder for which you are on seizure medication(s) a brain disorder, Guillian-Barre syndrome (a condition that causes paralysis) or other nervous system problem?	Yes □	No □	Don't Know □
6. For women: Are you pregnant or considering becoming pregnant in the next month or are you breastfeeding?	Yes □	No □	Don't Know □
7. Have you ever received a dose of COVId-19 vaccine? If yes, which vaccine product? □ Pfizer □ Moderna □ Another product_____	Yes □	No □	Don't Know □
8. Have you ever had a severe allergic reaction (e.g. anaphylaxis to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?	Yes □	No □	Don't Know □
Was the severe allergic reaction after receiving a COVID-19 vaccine?	Yes □	No □	Don't Know □
Was the severe allergic reaction after receiving another vaccine or another injectable medication?	Yes □	No □	Don't Know □
9. Have you received another vaccine in the last 14 days?	Yes □	No □	Don't Know □
10. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	Yes □	No □	Don't Know □
11. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	Yes □	No □	Don't Know □
12. Do you have a bleeding disorder or are you taking a blood thinner?	Yes □	No □	Don't Know □
13. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	Yes □	No □	Don't Know □

For Office Use Only

_____ _____ _____

Reviewer Printed Name/Signature Date Time