NSHC COVID-19 Vaccination Consent Form

Patient Name (Print): _____ Date of Birth: _____

Address: _____ Phone Number: _____

Purpose: To provide school-based vaccination for the SARS-Co-Vi-2 virus - which causes the COVID-19 disease.

This consent/refusal will be valid from date signed until May 1, 2022 unless replaced in writing.

Risks:

- Mild discomfort at the time of vaccination
- Pain at injection site
- Mild flu like symptoms for up to 5 days after vaccination (fever, chills, nausea, body aches)
- Rare incident of anaphylactic allergic reaction to vaccine component

Benefits: Protection of the patient and their community against the SARS-Co-Vi-2 virus which causes COVID19 disease. Reduction of the risk of community spread of the virus.

Consent to Vaccinate: **I have received, read, and understand the emergency use authorization fact sheet provided: *EUA Factsheet.*** I understand the risks involved with receiving the vaccine. I have had the opportunity to ask any questions and have received answers to my satisfaction**. I give consent for Norton Sound Health Corporation (NSHC) staff to provide vaccination for the SARS-CoVi2 virus to the above-named patient during school-based vaccination.** I understand that results will be recorded in the Norton Sound Health Corporation medicalrecords system. I understand that I have the right to refuse any proposed vaccination. The consent shall hold for all doses recommended by the ACIP, American Committee on Immunization Practices.

Consent to Release Medical Information: I give consent for NSHC and its medical providers to release medical information from this visit as necessary for coordination of care, public health, and/or completion of the claims/payments of the bill for services rendered. I request that any payments from my insurance company(ies) or medical program be made directly to Norton Sound Health Corporation. **NSHC will not balance bill or charge copay, co-insurance, deductible or any other charge tothe patient for COVID19 vaccination.** I understand that I may revoke this consent in writing at any time, except to the extent action has beentaken based on this authorization by NSHC.

COVID-19 Vaccination Screening Questions (Circle Response)		
Has the patient had a vaccine in the past 14 days?	YES	NO
Has the patient ever had shortness of breath, difficulty breathing, or any other severe allergic reaction to a vaccine or injectable medication?	YES	NO

□ **I <u>want</u> (or my child) to receive COVID-19 vaccination.**

□ **I <u>do not want</u> (or my child) to receive COVID-19 vaccination.**

Parent/Guardian PRINTED Name (or patient if > 18) : _____

Parent/Guardian Signature (or patient if > 18): _____

Date: _____

Date Administered	Site: Deltoid	Manufacturer	Lot #	Dose Number	Signature of Vaccinator
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