

Providing quality health services and promoting wellness within our people and environment.

NSHC COVID19 Vaccination Consent Form

 Patient's Name (Print)
 Date of Birth

 PO Box:
 Phone Number (cell for texted results):

 City/Village:
 Current Insurance:

Purpose: To provide school-based vaccination for the SARS-Co-Vi-2 virus which causes the COVID19 disease in a school-based testing strategy.

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

<u>Risks</u>:

- 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

<u>Benefits</u>: 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. <u>Consent to Test</u>: I give consent for Norton Sound Health Corporation (NSHC) staff to provide vaccination for the SARS-CoVi2 virus to the above-named patient during schoolbased vaccination. I understand that results will be recorded in the Norton Sound Health Corporation medical records 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.

<u>Consent to Release Medical Information:</u> 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 to the patient for COVID19 vaccination.

I understand that I may revoke this consent in writing at any time, except to the extent action has been taken based on this authorization by NSHC.

□ I <u>want</u> (or my child) to receive COVID19 vaccination.

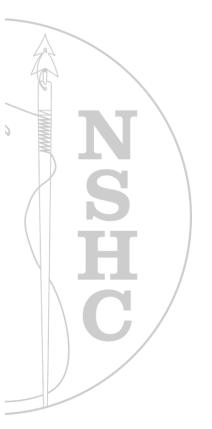
□ I <u>do not want</u> (or my child) to receive COVID19 vaccination.

Parent/Guardian Printed <u>Name</u> (or patient if age > 18): ______ Parent/Guardian Signature (or patient if age > 18): ______

T. 907.443.3311 | F. 907.443.2113 | P.O. BOX 966, NOME, ALASKA 99762-0966 | www.nortonsoundhealth.org

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Date:_____



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