



## **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.**

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 Test: 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 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.

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 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 want (or my child) to receive COVID19 vaccination.**

**I do not want (or my child) to receive COVID19  
vaccination.**

Parent/Guardian Printed Name (or patient if age > 18): \_\_\_\_\_

Parent/Guardian Signature (or patient if age > 18): \_\_\_\_\_

**NORTON SOUND HEALTH CORPORATION**

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

---

Date: \_\_\_\_\_



T. 907.443.3311 | F. 907.443.2113 | P.O. BOX 966, NOME, ALASKA 99762-0966 | [www.nortonsoundhealth.org](http://www.nortonsoundhealth.org)

**BREVIK MISSION | COUNCIL | DIOMEDE | ELIM | GAMBELL | GOLOVIN | KING ISLAND | KOYUK | MARY'S IGLOO | NOME | ST. MICHAEL  
SAVOONGA | SHAKTOOLIK | SHISHMAREF | SOLOMON | STEBBINS | TELLER | UNALAKLEET | WALES | WHITE MOUNTAIN**