TOE RIVER HEALTH DISTRICT COVID-19 CONSENT FORM

Please complete this form and return with a copy of your Medicare, Medicaid, or Insurance Card.

PLEASE PRINT: Date of Birth _____ **Age** _____

Name _____ _____

Last **First** **Middle** **Maiden**

Social Security Number: _____

Mailing Address _____

City _____ **State** _____ **Zip Code** _____

County of Residence _____ **Phone #** _____

1. Have you had close contact (within 6ft for at least 15 minutes) in the last 14 days with someone diagnosed with COVID-19, or has any health department or health care provider contacted you and advised quarantine? ..... ❑ No ❑ Yes

2. Have you had any of the following symptoms? ..... ❑ No ❑ Yes

(Fever, chills, shortness of breath or difficulty breathing, new cough, new loss of taste or smell, congestion/runny nose, headache, diarrhea, nausea/vomiting)

3. In the last two weeks have you had any immunizations? ..... ❑ No ❑ Yes

4. Do you have a bleeding disorder? ..... ❑ No ❑ Yes

5. Have you recently or are you currently taking anticoagulants (blood thinners)? ..... ❑ No ❑ Yes

6. If you answered yes to questions 4 or 5, do you have written permission from your primary care provider to receive the COVID-19 vaccine? ..... ❑ No ❑ Yes

7. Have you had any facial fillers (Botox, etc.)? ..... ❑ No ❑ Yes

Immunization Administered:

❑ COVID-19 Vaccine dose 1
❑ COVID-19 Vaccine dose 2

Date of second COVID-19 vaccine dose to be administered **Date** _____

❑ COVID-19 Vaccine verification card provided to patient
❑ Patient informed of V-Safe app
❑ COVID-19 VIS given

I authorize payment of the above named benefits to Toe River Health District for services received. I acknowledge that a copy of the Toe River Health District Notice of Privacy Practices was made available to me.

Patient's or Authorized Person's Signature _____ **Date** _____

FOR OFFICE USE ONLY:

TRHD USE ONLY							
	COVID-19	IMM DATE	DOSAGE ❑ 0.50 ml	ROUTE IM	SITE ❑ LD ❑ RD	MFGR Moderna	LOT #
	Nurse's Signature_____					Expiration Date:	
						Data Entry Date/Initials_____	

CVMS: _____ **CureMD:** _____

Label

Toe River Health District services and employment opportunities are offered to all people regardless of race, color, national origin, sex, religion, age, or disability.
Disposition: As POHR Manual destroy form in office after three years.

TOE RIVER HEALTH DISTRICT
Avery, Mitchell, & Yancey County Health Departments

Diane Creek, MSW
Health Director

Julia Sherrill, MD & Frank Craig, MD
Medical Directors

North Carolina Public Health
Jim Deaton, Chair
Board of Health

Patient Name:_____

Age:_____

Prevaccination Checklist for COVID-19 Vaccines

For Vaccine Recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If a question **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked.**is not clear, please ask your healthcare provider to explain it.

Prescreening Questions	Yes	No	I do not know
1. Are you feeling sick?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? Pfizer Moderna			
3. Have you ever had an allergic reaction to the following items?			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonscopy procedures.			
• Polysorbate			
• A previous dose of COVID-19 vaccine			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?			
5. Have you ever had a severe allergic reaction (anaphylaxis) to something?			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			

Form reviewed by: _____ Date:_____