

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

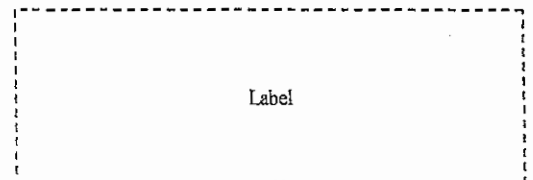
I authorize payment of the above named benefits to Toe River Health District for services received. I acknowledge that a copy of the Toe River Health District Notice of Privacy Practices was made available to me.

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

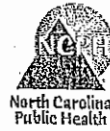
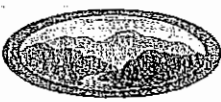
FOR OFFICE USE ONLY:

TRHD USE ONLY	COVID-19	IMM DATE	DOSAGE <input checked="" type="checkbox"/> 0.50 ml	ROUTE IM	SITE <input type="checkbox"/> LD <input type="checkbox"/> RD	MFGR Moderna	LOT #
	Nurse's Signature _____					Expiration Date: _____	
						Data Entry Date/Initials _____	

CVMS: _____ CureMD: _____



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.



Diane Creek, MSW
 Health Director

Julia Sherrill, MD & Frank Craig, MD
 Medical Directors

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 colonoscopy 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: _____