Salem Health Hospitals and Clinics

COVID-19 VACCINE CONDITIONS FOR TREATMENT, CONSENT & SCREENING

Salem Health® Hospitals & Clinics

SECTION 1: PATIENT INFORMATION (PLEASE PRINT)

Last Name	**First Name**	**Middle Name**
Race	**Ethnicity**	
Date of Birth	**Phone Number**	**Sex (select one)** ☐ **Male** ☐ **Female** ☐ **X**
Mailing Address		
City	**State**	**Zip code**

SECTION 2: INSURANCE POLICY INFORMATION – Primary Coverage

Insurance Name	**Subscriber/Policy Holder ID#**	**Group #**
Subscriber/Policy Holder Name	**Medicare Beneficiary Indicator** (Required for Medicare and Medicare Advantage)	
Mailing Address		
City	**State**	**Zip Code**
Date of Birth	**Subscriber Sex (select one)** ☐ **Male** ☐ **Female** ☐ **X**	
Relationship to Patient		

SECTION 3: CONDITIONS FOR TREATMENT

MEDICAL TREATMENT: I consent to Salem Health Hospitals and Clinics (SH), its staff or agents, to administer the COVID-19 vaccine. I understand that the COVID-19 vaccine requires two doses to be administered for it to be effective. I understand that all licensed professional healthcare providers that care for me are responsible and liable for their own actions. I acknowledge that SH cannot guarantee the outcome of the treatment.

FINANCIAL AGREEMENT: I agree to pay for all services and supplies rendered to me in accordance with the rates and financial policies in effect.

ASSIGNMENT OF INSURANCE BENEFITS: I assign to SH the right to receive benefit payments directly from my health insurance or health plan for reimbursement of the hospital, providers and other services I receive at SH. I am responsible for all charges not covered by my insurance policy(s). If I am entitled to Medicare or Medicaid benefits under Title XVIII of the Social Security Act, I request assignment of the benefit directly to SH. I understand that this assignment is final.

HEALTHCARE WORKER EXPOSURE/BLOOD TESTING: If any healthcare worker is exposed to my blood or other bodily fluids, I permit SH to test it. I understand that SH will test for things like Hepatitis B/C, HIV, or other communicable diseases.

NOTICE OF PRIVACY PRACTICES: I was offered the Notice of Privacy Practices, which describes how SH may use and disclose my healthcare information. I understand my information may be disclosed electronically. I can contact the Privacy Officer if I have questions or complaints.

PATIENT RIGHTS AND RESPONSIBILITIES: I was offered the Patient's Rights and Responsibilities information sheet.

SECTION 4: CONSENT FOR COVID-19 VACCINE

I certify that I am the patient and at least 16 years of age, or authorized to consent for vaccination for the patient.

I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 16 years of age and older(for Pfizer vaccine) or 18 years of age or older (for Moderna vaccine); and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.

I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation.

On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless SH and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.

SECTION 5: COVID-19 SCREENING QUESTIONS

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **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. If a question is not clear, please ask your healthcare provider to explain it.

#	Screening Questions	Yes	No	Don't Know
1.	Are you feeling sick today?	☐	☐	☐
2.	Have you ever received a dose of a COVID-19 vaccine? If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Another Product	☐	☐	☐
3.	Have you ever had a severe allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
	• 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 (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	☐	☐	☐
6.	Have you received another vaccine in the last 14 days?	☐	☐	☐
7.	Have you 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?	☐	☐	☐

Signature of Patient or Authorized Representative: _____ Date: _____

Print Patient Name: _____

----------**FOR SITE LOCATION USE ONLY**----------

MRN _____ **CSN** _____

FOR DOWNTIME USE ONLY

DOSE #	Site (Circle One)	Route	Manufacturer (Circle One)	Lot #	Vaccine Exp. Date	Administered By & Date/Time (Print Name)
☐ 1	LD RD	IM	Pfizer Moderna			DATE & TIME OF ADMINISTRATION
☐ 2	LD RD	IM	Pfizer Moderna			DATE & TIME OF ADMINISTRATION