SCHOOLCRAFT MEMORIAL HOSPITAL

☐ **SCMH Employee** **FIN**_____

COVID-19 Clinic Registration

Patient Information- Please Print in Ink

First Name _____ **Last Name** _____

Gender: **Male** **Female**

Date of Birth (MM/DD/YYYY): _____/_____/_____

Social Security # _____

Street Address/Apt No: _____

City/State/Zip: _____

Telephone #: _____

Email Address: _____

*******Insurance Information Required for First Vaccine Appointment at SMH OR If Changes Have Occurred Since Last Dose*******

Primary Insurance Carrier _____

Insurance ID# _____ **Insurance Group #**_____

Insurance #1 Address _____

Name of Cardholder _____ **Date of Birth** _____
(if different from person receiving vaccination)

Secondary Insurance Carrier *(if applicable)* _____

Insurance ID# _____ **Insurance Group #**_____

Insurance #2 Address _____

Name of Cardholder _____ **Date of Birth** _____
(if different from person receiving vaccination)

If *No* Insurance – ☐ **Self-Pay (No out of pocket expense to patient)**

SCHOOLCRAFT MEMORIAL HOSPITAL

Consent

I understand that I am receiving the following vaccine: (Circle One) **Pfizer** **Moderna** today.

(Circle One) **Dose #1** **Dose #2** **Dose #3**

(If 2nd or 3rd Dose, when was last dose you received?) _____

I have read the COVID19_Vaccine_EUA_Fact_Sheet_for_Recipients regarding the COVID-19 EAU (Emergency Authorization Use) vaccine. I understand the benefits and risks of the COVID-19 vaccination as described. I request that the vaccine be given to me. I understand the vaccination is being provided by PfizerBioNTech or Moderna. I expressly release Schoolcraft Memorial Hospital from any liability resulting from the COVID-19 vaccine.

I agree to remain under observation for at least 15 minutes, or 30 minutes if I have had an anaphylactic reaction in the past. Should I leave before that period lapses, I expressly release Schoolcraft Memorial Hospital from any liability resulting from any adverse reaction to the vaccine which may occur during that period and thereafter. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense.

I understand side effects may include but are not limited to redness/soreness/swelling at the injection site, fever, fatigue and headache, muscle pain, nausea, malaise, and lymphadenopathy. Severe reactions may include anaphylaxis and death. I understand that I should seek medical attention immediately at an Emergency Department if symptoms of anaphylaxis occur.

In the event a Schoolcraft Memorial Hospital (SMH) employee is exposed to my blood or other body fluids, I agree to have my blood tested for HIV & Hepatitis & the results released to Schoolcraft Memorial Hospital/exposed person, but not to anyone else unless required/authorized by law.

☑ **I consent to the terms above.**

Signature _____

Today's Date _____

Office use only:

Pfizer 0.3 mL or Moderna 0.5mL (Circle one) **Lot#**_____ **Exp. Date**_____

given **IM in the** _____ **Right Deltoid** _____ **Left Deltoid.**

Administered by: _____ Date: _____