☐ **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)**

Consent

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

Dose **#1** **Dose #2** **Dose #3** **Dose #4** **Bivalent Booster** (Circle One)

(If 2nd, 3rd, or 4th 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 Pfizer BioNTech 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/Bivalent 0.3 mL or Pfizer 0.2ml (Pediatric) or Moderna 0.5mL or Moderna 0.25mL

Lot#__________ **Exp. Date**__________ given **IM in the** _____**Right Deltoid** _____ **Left Deltoid**

Administered by: ____________________________ Date: ________________________