V A C C I N E A D M I N I S T R A T I O N C O N S E N T F O R M

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| **SECTION 1 – INFORMATION ABOUT THE PERSON RECEIVING THE VACCINE** | | |
| Name: Date of Birth: / / Phone: ( ) Address: City: State: Zip Code: Insurance Carrier Name: ID #: Group #: Policy Holder Name (if different): Policy Holder Date of Birth: Vaccines Needed: Flu Pneumonia Shingles Td Tdap Hepatitis A Hepatitis B Meningitis HPV Other:  Primary Care Provider Name: Phone: ( ) Fax: ( ) | | |
| **SECTION 2 – QUESTIONS TO DETERMINE VACCINE ELIGIBILITY ( c ircle YES or NO)** | | |
| 1. In the last 10 days, have you or someone with whom you’ve been in close contact been diagnosed with COVID-19? | YES | NO |
| 2. Are you sick today or do you have any of these symptoms: fever, chills, shortness of breath, body aches, loss of taste/smell | YES | NO |
| 3. Do you have any long-term health conditions? *(ex: heart disease, diabetes, asthma, COPD, kidney disease, anemia)* | YES | NO |
| 4. Do you have allergies to medications, foods, or latex? *(ex: egg, bovine, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast)* | YES | NO |
| 5. Have you had any serious reactions from a vaccine? | YES | NO |
| 6. Are you taking biological injectables, steroids, anticancer drugs, antivirals, or have you had recent radiation treatments? | YES | NO |
| 7. Do you have a seizure disorder, brain disorder, Guillain-Barre Syndrome, or nervous system disorder? | YES | NO |
| 8. Do you have a problem with your immune system, history of AIDS, bone marrow disease or tuberculosis? | YES | NO |
| 9. During the past year, have you received blood or blood products or been given immune (gamma) globulin? | YES | NO |
| 10. Have you had any vaccinations in the past 4 weeks? | YES | NO |
| 11. Are you age 65 years or older? Age: | YES | NO |
| 12. **FOR WOMEN:** Are you pregnant, or is there a chance you could become pregnant in the next month? | YES | NO |
| **SECTION 3 – PLEASE READ CAREFULLY AND ACKNOWLEDGE WHERE APPROPRIATE** | | |
| I hereby give my consent to the Alexandria Emergency Hospital (AEH) to administer the vaccine(s) (the “Services”) I have requested below.  **With my initials, I certify that:**  I am: (i) the Patient and at least 18 years of age; (ii) the parent or guardian of the minor Patient; or (iii) the legal guardian of the Patient; or (iv) a person authorized under the law of another state or a court order to consent for the child; OR  The persons identified under (ii), (iii), or (iv), in the preceding sentence are unavailable and I have authority to consent to the immunization of the child because I am a (i) grandparent; (ii) adult brother or sister; (iii) adult aunt or uncle; (iv) stepparent; or (v) another adult who has actual care, control, and possession of the child and has written authorization to consent for the child from a parent, managing conservator, guardian, or other person who, under the law of another state or a court order, may consent for the child; additionally, I certify that I do not have knowledge of any express refusals or withdrawn authorizations of consent and have not been told not to give consent for the child.  I understand that any Protected Health Information (“PHI”) I provide AEH will only be used or disclosed by AEH in accordance with AEH Health Insurance Portability and Accountability Act (“HIPAA”) Notice of Privacy Practices. By signing below I acknowledge receipt of such HIPAA Notices of Privacy Practices and consent to the uses and disclosures of PHI described therein. While AEH reserves the right to not do so, I consent to AEH reporting my immunization information to the State Immunization Registry. Should AEH elect to  report my immunization history to the Louisiana central immunization registry, LINKS, I further understand that my immunization information may be accessed by other health care providers, educators, public health representatives, state agencies and certain insurance payers. I further authorize AEH to (1) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment or otherwise, (2) submit a claim to my insurer for the below requested items and services, and (3) request payment of authorized benefits be made on my behalf to AEH with respect to the below requested items and services. I further agree to be fully financially responsible for any co-sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if AEH invoices me after the time of service, upon receipt of such invoice. Please note: for non-prescription insurance (i.e. medical/ health insurance), your insurance will notify you and AEH the exact copay/coinsurance amount due once they receive and process the claim. You may receive an invoice for any amounts due, up to and including the total amount of the claim.  **RELEASE, IMDEMNITY AND DISCLAIMER**  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 below vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements/EUA Fact Sheet on the vaccine(s) 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 additionally acknowledge that I have received a copy of the AEH Pharmacy notice of privacy. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care provider.  On behalf of myself, my heirs and personal representatives, I further hereby WAIVE, RELEASE, and AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS (including for costs and attorney’s fees) AEH, its staff, agents, employees and corporate affiliates 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 Services listed below, even should such damages or losses result from AEH’s negligence.  **Patient Signature: Date:**  (Parent or Legal Guardian, if minor)  **Vaccinator:**  Lot # Manufacturer: Site of Administration: RD LD Dose: 1st 2nd | | |