KOHALA COAST URGENT CARE

MODERNA, JOHNSON&JOHNSON, PFIZER
COVID-19 VACCINATION CONSENT/REGISTRATION

INSTRUCTIONS:
PLEASE COMPLETE THE ENTIRE FORM. MISSING INFORMATION MAY RESULT IN DELAY IN REGISTRATION PROCESS.

____ 18 YEARS OF AGE OR OLDER, IF NOT SEE ATTACHED MINOR CONSENT FORM

____ ID Not Available

DATE: _____

NAME: (LAST) _____ **(FIRST)** _____ **(M)** _____

DOB: _____/_____/_____ **SEX:** ☐ MALE ☐ FEMALE ☐ NON-BINARY **MARITAL STATUS**: ☐ S ☐ M ☐ D ☐ W

SOCIAL SECURITY NUMBER:_____-____-_____

RACE: (SELECT ONE): ☐ HISPANIC/LATINO ☐ AFRICAN AMERICAN ☐ ASIAN ☐ PACIFIC ISLANDER/NATIVE HAWAIIAN

☐ AMERICAN INDIAN/ALASKA NATIVE ☐ WHITE ☐ DECLINE TO ANSWER

ETHNICITY: ☐ NOT HISPANIC/LATINO ☐ HISPANIC/LATINO ☐ DECLINE TO ANSWER

PRIMARY LANGUAGE SPOKEN IN HOME: ☐ ENGLISH ☐ SPANISH OTHER: _____

ALLERGIES: ☐ _____ ☐ **NO KNOWN**

ALLERGIES

MAILING ADDRESS: _____

CITY: _____ **STATE**: _____ **ZIP**: _____

PHONE #: _____ **EMAIL**: _____

EMERGENCY CONTACT: _____**PHONE** _____

EMPLOYER: _____ **EMPLOYER PHONE#:**_____

INSURANCE INFORMATION

PRIMARY INSURANCE CO: _____**EFFECTIVE DATE**: _____/_____/_____

POLICY HOLDERS NAME/RELATIONSHIP: _____**DOB**: _____/_____/_____

SUBSCRIBER #: _____ **GROUP#**: _____

SECONDARY INSURANCE CO: _____**EFFECTIVE DATE**: _____/_____/_____

POLICY HOLDER NAME/RELATIONSHIP:_____ **DOB**: _____/_____/_____

SUBSCRIBER #: _____ **GROUP#**: _____

RELATIONSHIP TO PATIENT: _____

POLICYHOLDER'S EMPLOYER: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize KOHALA COAST URGENT CARE LLC or insurance company to release any information required to process my claims. I also consent to medical treatment from KOHALA COAST URGENT CARE LLC.

SIGNATURE:_____ **DATE**:_____

HAVE YOU PREVIOUSLY BEEN VACCINATED WITH COVID-19 VACCINE?

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YES___ PRODUCT NAME: _____ DATE RECEIVED:_____/_____/_____

	YES	NO	DON'T KNOW
ARE YOU FEELING SICK TODAY?			
DO YOU HAVE ALLERGIES TO ANY CONTENTS IN THIS VACCINE? (Polyethylene glycol)			
HAVE YOU EVER HAD A SEVERE/ANAPHYLACTIC REACTION TO ANY VACCINE?			
DO YOU HAVE A BLEEDING DISORDER OR ON ANY BLOOD THINNERS?			
ARE YOU IMMUNOCOMPROMISED OR ON ANY MEDICATIONS THAT AFFECT YOUR IMMUNE SYSTEM?			
HAVE YOU PREVIOUSLY RECEIVED A COVID-19 VACCINE?			
HAVE YOU HAD ANY OTHER VACCINATIONS IN THE PAST 14 DAYS?			
FEMALE PATIENTS: **a. Are you or could you be pregnant?** **b. Are you breastfeeding?**			
HAVE YOU HAD A POSTIVE COVID-19 TEST IN THE PAST 90 DAYS?			
IF YOU WERE DIAGNOSED WITH COVID IN THE PAST 90 DAYS DID YOU RECEIVE ANTIBODY OR CONVALESCENT PLASMA FOR TREATMENT OF YOUR COVID ILLNESS?			
HAVE YOU EVER HAD ANY COSMETIC DERMAL FILLER?			

ACKNOWLEDGEMENT/CONSENT

I am at least 18 years of age and consent to receive the COVID-19 vaccination.

By providing your mobile number, you agree that KOHALA COAST URGENT CARE LLC (or affiliate or designee) may send you future communications via SMS, containing, but not limited to, important healthcare information, updates, or reminders regarding your vaccination process.
I was provided the Fact Sheet for Recipients for the COVID-19 vaccine I am receiving. I read and/or had explained to me the information provided about the vaccine. I was given the opportunity to ask questions and any questions I had were answered to my satisfaction. I understand the risk and benefits of the vaccination and I am voluntary choosing to receive the vaccination.

I understand I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. If I have had a previous severe reaction to a vaccine or at discretion of medical provider on site, I will be monitored for 30 minutes. I understand if I experience any side effects after leaving the vaccination area, I should call my doctor, or if the side effects are severe, I should call 911.

Patient Name: (print) _____ **Patient Signature**: _____

FOR OFFICE USE ONLY
(PROVIDER MUST PRINT LEGIBLY)

EVENT/LOCATON: _____

MANUFACTURER: ☐ **PFIZER** ☐ **MODERNA** ☐ **JOHNSON/JOHNSON** **DOSE:** ☐ 1ST ☐ 2ND ☐ Booster

ROUTE: ☐ IM OTHER: _____ **LOCATION:** ☐ RT DELTOID ☐ LT DELTOID OTHER: _____

LOT# _____
Exp. Date_____
Vaccine Manufacturer_____
NDC Number_____
VAMS #_____

Date Dose Administered_____
Time Administered_____

VACCINATOR: _____
FIRST NAME/LAST NAME/ CREDENTIALS