Northern Light
Home Care & Hospice

COVID 19 Vaccine Screening and Consent Under 18

First Name _____Middle Initial _____Last Name_____

DOB (month/day/year) _____/_____/_____ Primary Phone_____

Gender (circle one): M / F / Prefer not to say Preferred Language_____

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown ☐ Choose not to answer

Race ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander
☐ Black or African American ☐ White ☐ Other Race

Are you disabled? ☐ Yes ☐ No ☐ Choose not to answer

Mailing Address_____

City_____State_____Zip_____

Email _____ Employer_____

Insurance _____Ins. ID_____SSN_____

Subscriber Name _____Relationship _____SSN _____DOB_____

EMERGENCY CONTACT INFORMATION

Full Name_____Relationship_____Phone #_____

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Vaccine Provided: ☐ Pfizer(2 doses, 21 days apart)

Lot# Dose 1	**Dose, Route, Site**	**Provider's Signature & Title**	**Date Dose #1**
	IM, 0._____ml, (Circle which side) **R L Deltoid**		
Lot# Dose 2	**Dose, Route, Site**	**Provider's Signature & Title**	**Date Dose #2**
	IM, 0._____ml (Circle which side) **R L Deltoid**		
Lot# Dose 3/Booster 16 & 17 years old ONLY	**Dose, Route, Site**	**Provider's Signature & Title**	**Date**
	IM, 0._____ml (Circle which side) **R L Deltoid**		

Questions	**Circle Answer**
1. Have you tested positive for COVID-19 in the last 14 days?	**YES NO**
2. Have you received COVID-19 Monoclonal Antibodies or Convalescent Plasma within the last 90 days?	**YES NO**

Patient Name: _____

4. Have you had an anaphylactic reaction to a previously administered COVID-19 vaccine or any component of a COVID-19 vaccine? **YES** **NO**

5. Do you have an allergy to any vaccine? **YES** **NO**
Pfizer COVID-19 vaccine have NO Latex, Egg, or Preservative.

6. Have you had a serious adverse reaction to a previous COVID-19 vaccine? **YES** **NO**
A NORMAL reaction after COVID vaccination includes the following. These may be more severe after the second dose.

I. Arthralgia (ache or pain in joints)
II. Fatigue
III. Fever
IV. Chills
V. Headache
VI. Myalgia (ache or pain in muscle)
VII. Nausea
VIII. Local pain or redness at injection site

7. Are you pregnant? **YES** **NO**

I am pregnant or breastfeeding, can I get vaccinated? *Yes, but is recommended that you receive some added information about the trials leading up to approval and the known risks of the vaccines.*

- *Neither the Pfizer/BioNtech vaccine has been studied in individuals who are or may become pregnant, because of this the American College of Obstetricians and Gynecologists suggest a patient-provider conversation on the risks and benefits of vaccination for individuals*
- *While some individuals in the clinical trials did become pregnant, there were not enough to make any determinations about safety.*
- *While mRNA vaccines are new for use in humans, the mRNA in the vaccine is degraded quickly by normal cellular processes and does not enter the nucleus of the cell. Based on current knowledge, experts believe that mRNA vaccines are unlikely to pose a risk to the pregnant person or the fetus. However, the potential risks of mRNA vaccines to the pregnant person and the fetus are unknown because these vaccines have not been adequately studied in pregnant people.*
- *All vaccines may cause immune reactions including fevers. Fevers may cause problems in fetal development, though this risk is small and consequences from vaccination in general during pregnancy are rare.*
- *Due to the consequences of infection and COVID-19 disease, in populations where mRNA vaccines are recommended, such as in healthcare workers, vaccination should be offered for individuals who are or may become pregnant especially where community spread of the disease is a concern.*
- *Lactating individuals were not included in most clinical trials. ACOG recommends that the theoretical concerns regarding the safety of vaccinating lactating individuals does not outweigh the potential benefits. Breastfeeding does not need to be discontinued in patients receiving a COVID-19 vaccine.*

I understand the risks and benefits of receiving the COVID-19 vaccine during pregnancy and agree to receive the vaccination. _____ ***Initial***

8. Do you have any immunocompromising conditions (HIV, solid organ transplant, receiving immunosuppressive therapies, etc.)? **YES** **NO**
If yes, be sure to discuss optimal scheduling of the vaccination with your provider

IF YES:
I am immunocompromised from a medication that I take/from a condition, can I take the vaccine?
Yes, the COVID-19 vaccine is safe for you to take. If you have a compromised immune system the vaccine may be less effective, but it should not create additional side effects.
Please note that immunocompromised patients were not included in the clinical trials, except for a small number of patients with HIV.
I understand that COVID-19 vaccines have not been studied in immune compromised patients and agree to receive the vaccination. _____ ***Initial***

Patient Name: _____

- *I understand that failure to provide an accurate answer to any of the COVID-19 screening questions could result in increased risk of harm to me from vaccination.*
- *I understand that this COVID-19 vaccine medication is approved under an Emergency Use Authorization (EUA) from the FDA and has not received full FDA approval.*
- *I have been advised of, understand, and acknowledge the need to wait for 15 minutes after receiving the COVID-19 vaccine before operating any heavy equipment and/or driving a vehicle given the risk of adverse reaction, including loss of consciousness. If I choose to operate heavy equipment and/or drive a vehicle within 15 minutes of receiving a vaccination, I understand and acknowledge that I am accepting sole responsibility for all associated risks whether known or unknown; holding Northern Light Health, its employees, agents, contractors and officers, harmless from all injury, harm and/or damages associated with my decision to operate heavy machinery and/or drive a vehicle; and am agreeing to indemnify and/or forever discharge Northern Light Health, its agents, employees, officers, directors, insurers, subsidiaries and affiliates for, from and against any and all manner of claims, demands, actions, liability, damages, claims for punitive or liquidated damages, claims for attorney's fees, costs and disbursements, individual or class action claims, and demands of any other kind whatsoever whether known or unknown, in law or equity, contract or tort, made or brought by any third party arising out of or in any way relating to my decision to operate heavy equipment and/or drive a vehicle within 15 minutes of receiving the COVID-19 vaccine. The acknowledgments and releases described in this paragraph shall be binding upon my heirs, personal representatives, administrators, executors, and assigns.*
- *I understand the benefits and risks of the getting the COVID-19 vaccine, and that no medication is without risk of harm, even in patients with no risk factors.*

Signature of Patient: _____ Date (Mo/Day/Yr):_____

Signature of Parent or Guardian (If under 18 years of age):_____Date (Mo/Day/Yr):_____

We have four important documents we want you to be aware of:

- *Our Notice of Privacy Practices that explains your rights when it comes to your health information, and how we use and disclose this information.*
- *Your Rights and Responsibilities as a patient.*
- *The state of Maine participates in a statewide health record exchange called HealthInfoNet. We share healthcare information with this exchange unless you choose to opt out. If you want to opt out, the opt out form is available on the HealthInfoNet website or the Northern Light Health website.*
- *A summary of our Financial Assistance Policy, which explains the financial assistance program we offer to those who qualify.*

- *I agree to the Northern Light Health Consent to Treatment. I acknowledge that I can request a copy of the (a) Northern Light Health Consent to Treatment, (b) Northern Light Health Notice of Privacy Practices, (c) Patient's Rights and Responsibilities, (d) information on the health information exchange including the opportunity to opt out, and (e) plain language summary of the Northern Light Health Financial Assistance Policy from clinic staff.*
- *I consent to receive services.*
- *I consent to be vaccinated for COVID-19.*

I understand that the vaccine I am consenting to requires two doses to produce immunity to COVID-19 and that it is necessary that I receive both doses of the vaccine as scheduled.

Signature of Patient: _____ Date (Mo/Day/Yr):_____

Signature of Parent or Guardian (If under 18 years of age):_____Date (Mo/Day/Yr):_____