HEARTLAND
COMMUNITY HEALTH CENTER

346 MAINE ST., SUITE 150
LAWRENCE, KS 66044
PHONE: 785.841.7297
FAX: 785.856.0375
WWW.HEARTLANDHEALTH.ORG

| First Name: | Last Name: | Date of Birth: |
|---|---|---|
| | | |

| COVID-19 Screening Questions | YES | NO | Do not Know |
|---|---|---|---|
| In the past two weeks, have you tested positive for COVID-19 | | | |
| In the past two weeks, have you had contact with anyone who tested positive for COVID-19 | | | |
| Do you currently or have you in the past 14 days, had a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of tase or smell, sore throat, nausea, vomiting, or diarrhea? | | | |

| Immunization Screening Questions | Yes | No | Do Not Know |
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| Are you sick today? (For example: a cold, fever, or acute illness) | | | |
| Do you have allergies or reactions to any foods, medications, vaccines, or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) | | | |
| Do you have allergies to any of the components of the Pfizer BioNTech COVID-19 vaccine? (Each dose of the Pfizer BioNTech COVID-19 Vaccine contains the following ingredients: lipids (0.43 mg (4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 0.05 mg 2[(polyethylene glycol)-2000]- N,N-ditetradecylacetamide, 0.09 mg 1,2-distearoyl-sn-glycero-3-phosphocholine, and 0.2 mg cholesterol), 0.01 mg potassium chloride, 0.01 mg monobasic potassium phosphate, 0.36 mg sodium chloride, 0.07 mg dibasic sodium phosphate dihydrate, and 6 mg sucrose. The diluent (0.9% Sodium Chloride Injection, USP) contributes an additional 2.16 mg sodium chloride per dose. | | | |
| Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a hospital setting? | | | |
| Have you had a seizure? Do you have a neurological disorder or history of Guillen Barre syndrome? | | | |
| Do you take anticoagulation medication? i.e., Warfarin, Coumadin, or other blood thinner. | | | |
| Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease, anemia, or any other blood disorders? | | | |
| Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, or any other immune system problem? | | | |
| Do you have a weakened immune system or in the past 3 months, taken medications that suppress your immune system such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments? | | | |
| During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? | | | |
| For women, are you pregnant or is there a chance you could become pregnant during the next month? | | | |
| Have you received any vaccinations or a TB skin test in the past 4 weeks? | | | |

**I understand the benefits and risks of the Vaccine and I expressly consent, request, and authorize the administration of the Vaccine. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Heartland Community Health Center, each Provider and the applicable staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liability or claims, whether known or unknown, arising out of, in connection with, or in any way related to the Services.**

**I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registration ("State Registry") and my state's health information exchange ("State HIE"); and (b) the Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination.**

**I further authorize the applicable Provider to: (a) release my medical or other information, including my communicable disease**

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**(including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE to my healthcare professionals, Medicare, Medicaid, or other third- party payers as necessary to effectuate care or payment; (b) submit a claim to my insurer for the Services; and (c) request payment or authorized benefits be made on my behalf to the applicable Provider with respect to the Services.**

**I acknowledge that, depending upon my state's law, I may prevent, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the Provider: (a) the disclosure of my vaccination information by the Provider to the State HIE and/or**
**State Registry: or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The Provider will, if my state permits, provide me with an Opt-Out Form. I understand that I may need to consent, depending on my state's law, and to the extent so required, I hereby do consent by signing below to the Provider reporting my vaccination information to the State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent Form. Unless I provide the Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my vaccination information to or through the State HIE as required or permitted by law.**

**Photocopies/electronic transmissions/faxes of this consent and any signatures are to be considered as valid originals.**

**MY SIGNATURE BELOW INDICATES THAT I VOLUNTARILY AGREE TO ALL OF THE ABOVE AND THAT THE NATURE OF THIS CONSENT WAS EXPLAINED TO ME AND THAT I HAD THE OPPORTUNITY TO ASK ANY AND ALL QUESTIONS REGARDING THE ABOVE AND MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I UNDERSTAND THE BENEFITS AND RISKS OF THE VACCINE AND I EXPRESSLY CONSENT, REQUEST AND AUTHORIZE THE ADMINISTRATION OF THE VACCINE. I HAVE BEEN PROVIDED WITH THE CDC'S VACCINE INFORMATION SHEET(S) OR THE EMERGENCY USE AUTHORIZATION (EUA) PATIENT FACT SHEET CORRESPONDING TO THE VACCINE THAT I AM RECEIVING.**

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| **Print Name (Signatory):** | | **Signature:** | | **Date:** |
| **If Patient is a Minor -Guardian Name:** | | | | |
| **Relationship to Patient: if applicable** | **Spouse** | **Power of Attorney** | **Legal Guardian** | **Other, Please Specify(If "Other", refer to witness section)** |
| **Witness (use for Relationship To Patient is "Other"): (optional)** | | | | |
| **Signature:** | | **Print Name:** | | |