Fetter Health Care
NETWORK

CCSMS Dates for scholars 16 and over will be:
Shot 1: May 5 9am to 11am
Shot 2: May 26 9am to 11am
Please bring this form with you on Wednesday, May 5th or email it to Frontoffice@charlestonmathscience.org

COVID-19 VACCINE CONSENT FORM

Name: ____________________________________ **Birthdate**: _______/_______/_______ **Age**: _______ **SS#**: _______-_______-_______

____**NEW PATIENT** ____**ESTABLISHED PATIENT** **Sex**: ☐ Male ☐ Female **Email Address**: ____________________________________

Race: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other **Ethnicity**: ☐Hispanic ☐Non-Hispanic

Address: ____ **City**: ____________________ **State**: ________ **Zip**: __________

Phone: ____ **Do you have insurance?** ☐ No ☐ Yes

INSURANCE INFORMATION

Please note, insurance is not required.

(Please give your insurance card to registration)

Primary Insurance: ____
Subscriber's Name: _________________________________ Date of Birth: _______________
Group No: _______________________________________
Policy No: _______________________________________
Client's relationship to subscriber: _________________________________

The above information is true to the best of my knowledge. If qualified, I authorize billing to my insurance company and release of information required to process my claims. I authorize my insurance benefits be paid directly to Fetter Health Care Network (FHCN).
_______________ Initial

The following questions will help determine if there is any reason you should not receive a COVID immunization injection.
Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.

Has the person to be vaccinated ever received a COVID-19 vaccine?	☐ No ☐Yes
If yes, date: ____ Type/Brand of COVID: ☐Pfizer ☐Moderna ☐ Other	
Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex?	☐ No ☐Yes
List all allergies: ____	
Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy?	☐ No ☐Yes
Is the person to be vaccinated sick today?	☐ No ☐Yes
Is the person to be vaccinated pregnant or breastfeeding?	☐ No ☐Yes
Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner?	☐ No ☐Yes
Has the person to be vaccinated received any other vaccines in the past 14 days?	☐ No ☐Yes
Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19?	☐ No ☐ Yes
Does the person to be vaccinated have a weakened immune system caused by something such as HIV infection, cancer or do you take immunosuppressive drugs or therapies?	☐ No ☐ Yes

I have read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 vaccine and a copy of the fact sheet was provided to me. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian).
I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE PRIOR TO LEAVING.

Print Client Parent/Guardian name, if different from client ____

Client/Parent/Guardian Signature: ____Date: ____/_____/_____

FOR CLINIC USE ONLY

Clinic site: ____________________________ ***Date 1st dose administered***: _____/______/______ ***Date 2nd dose due***: _____/______/_______

Vaccine Manufacturer: *Moderna* ***OR*** *Janssen* ***Lot number***: _______________________ ***Site of IM injection***: *RDT or LDT* ***Dose***: *0.5ml*

Print name and title of vaccine administrator: ____

Created: 01/15/2020
Revised: 01/22/2021
Revised: 02/03/2021
Revised: 03/27/2021