TAZEWELL COUNTY HEALTH DEPARTMENT CONSENT FORM

Date: _____ Date of Birth: _____/_____/_____

Last Name: _____ Legal First Name: _____ *(NO NICKNAMES)* Middle Initial:_____

Address: _____ City:_____ State: Illinois Zip:_____

Email address:_____ Phone Number:_____

Insurance Information: SENIORS: PLEASE PROVIDE YOUR MEDICARE POLICY NUMBER

☐ **Yes, I have insurance coverage**

Insurance Name: _____ *(Examples: Molina, Medicare, Medicaid, Blue Cross Blue Shield, United Healthcare, UMR)*

Policy or Subscriber ID: _____ Group Number (if any): _____

Policy Holder's Name: _____ Date of Birth: ____/____/_____

☐ **No, I do not have any medical insurance coverage at all**

Notice of Privacy Policy: (PLEASE INITIAL)

_____I acknowledge I was offered a copy of Tazewell County Health Department's Notice of Privacy Policy.

Authorization to Release Information/Financial Responsibility: (PLEASE INITIAL)

_____I authorize the release of any medical information to the Centers for Medicare and Medicaid Services (CMS), my insurance carrier(s), or other entities necessary to determine insurance benefits or benefits payable for related medical services provided to me by Tazewell County Health Department. I also understand insurance billing is a service provided by TCHD and I am responsible for the entire and/or balance of my bill once my insurance(s) have been billed if there is a balance. Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

Consent to Test/Treat/Provide Services:

I authorize Tazewell County Health Department to provide testing, administer treatment, or provide appropriate services as deemed necessary for the care of the patient named below. I certify that I am the patient, parent or legal guardian of the patient. I have read or have had explained to me information about the vaccines/services to be given today. I have had the opportunity to ask questions that have been answered to my satisfaction. I understand that this record will be maintained by the Tazewell County Health Department and immunizations will also be maintained in a confidential computerized immunization registry, and that I can choose to opt out of the registry by completing an "Opt Out of Registry" form at each immunization visit.

I understand I have the right to revoke this authorization by giving written notice to Tazewell County Health Department. This authorization is in effect for one year from the date below.

Signature:_____ Printed Name of Signee:_____
(Parent or Legal Guardian if Patient is a minor)

Date:_____

TAZEWELL COUNTY HEALTH DEPARTMENT
CONSENT FORM

LOT STICKER

Person receiving vaccine:

Last Name_____ First Name_____ Middle Initial_____

Date of Birth _____/_____/_____ Gender: Male Female Other Unknown

ETHNICITY

Non-Hispanic/Non-Latino

Hispanic/Latino

Unknown

RACE

White Black/African-American Asian

Hispanic/Latino American Indian/Alaska Native Other

Native Hawaiian or other Pacific Islander Unknown

	PLEASE ANSWER ALL QUESTIONS	YES	NO	DON'T KNOW
1.	Do you feel sick today or have you had a fever within the last 48 hours?			
2.	Have you ever received a dose of COVID-19 vaccine?			
3.	Have you had a positive COVID-19 test or been diagnosed with COVID-19? If yes, have you completed the isolation period and fully recovered?			
4.	Have you received convalescent plasma or passive antibody therapy as treatment for COVID-19? If yes, what was the date? _____			
5.	Do you have a bleeding disorder or take a blood thinner?			
6.	Have you ever had a severe allergic reaction to anything listed below? (*Severe reaction includes anaphylaxis or hives/swelling/wheezing/difficulty breathing within 4 hours that required a hospital visit or treatment with an Epi-Pen.)*			
6a.	A component of the COVID vaccine (Polysorbate or Polyethylene Glycol, found in laxatives or colonoscopy prep medications)			
6b.	Any other vaccine or an injectable medication			
6c.	Food, pets, an environmental irritant, or oral medication			

Your signature on the back of this form verifies that you have read and understand the questions above, and have answered the questions to the best of your knowledge.

NURSING STAFF ONLY:
RECOMMENDED OBSERVATION PERIOD 15 MINUTES 30 MINUTES (for reaction in #6c)

DATE GIVEN:_____ RIGHT DELTOID LEFT DELTOID OTHER_____ DOSE 1

TIME GIVEN: _____ TIME RELEASED AFTER OBSERVATION:_____ DOSE 2

DOSE 3

Administering Nurse Signature_____ Date:_____

Patient/Parent/Guardian provided: BOOSTER

_____EUA Fact Sheet _____Vaccination Card _____Return Date _____Comfort Care _____V-Safe Info