Premier Medical Group USA

aspenmedical

COVID-19 VACCINATION CONSENT/REGISTRATION

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

ELIGIBILITY SCREEN

PHASE 1:

☐ **1A** - HEALTHCARE WORKERS/HEALTHCARE SUPPORT OCCUPATIONS/EMS WORKERS/LTC FACILITY STAFF AND RESIDENTS

☐ **1B**- **ADULTS 75 AND** OLDER/PRIORTIZED- PROTECTIVE SERVICE OCCUPATIONS/EDUCATION AND CHILDCARE PROVIDERS/ESSIENTIAL WORKERS

☐ **1C- ADULTS 65-74 YEARS** OF AGE/ADULTS LIVING IN SHELTERS OR OTHER CONGREGATE LIVING SETTINGS WITH VULNERABLE POPULATIONS/PEOPLE WITH HIGH-RISK MEDICAL CONDITIONS AT INCREASED RISK FOR SEVERE COVID-19 DIESEASE

PHASE 2:

☐ GENERAL POPULATION/ADDITONAL HIGH-RISK, CRITICAL POPULATIONS/ANY REMAINING PHASE 1a,1b,1c

DATE: _____

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

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

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

☐ AMERICAN INDIAN/ALASKA NATIVE TRIBAL AFFILIATION: _____ ☐ DECLINE TO ANSWER

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

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

ALLERGIES: ☐ **NKA** _____

ADDRESS: _____

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

PHONE #: _____ **EMAIL**: _____

EMERGENCY CONTACT: _____**PHONE #**: _____

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

INSURANCE INFORMATION

PRIMARY INSURANCE CO: _____ **EFFECTIVE DATE**: _____ **POLICY #**:_____

GROUP #: _____ **POLICY HOLDERS NAME**: _____

DOB: _____ **SS#**: _____-____-_____

SECONDARY INSURANCE CO: _____ EFFECITIVE DATE: _____ POLICY #: _____

GROUP #: _____ **POLICY HOLDER NAME**:_____

DOB: _____ **SS#**: _____-____-_____

RELATIONSHIP TO PATIENT: _____ POLICYHOLDER'S EMPLOYER: _____

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	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 PMG USA and/or Aspen Medical (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, 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)

DATE: _____ EVENT/LOCATON: _____

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

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

VACCINATOR: _____
(FIRST INITIAL/LAST NAME/CREDENTIALS)