COVID VACCINATION CONSENT FORM—please PRINT legibly

To be completed by participant/guardian (12 years and older)

HealthySolutionsInc
for healthier communities

Patient Name: _____ Sex: ☐ M ☐ F Phone: (_____) _____-_____

Address: _____City: _____ ST: _____ Zip: _____

DOB (required): _____ / _____ / _____ Age: _____ Email: _____
MM DD YYYY

Please answer the questions below. A "Yes" answer does not necessarily mean you should not be vaccinated. It means we may need to ask more questions. it If you have any questions, please ask now before receiving the vaccine

1. Are you 12 years of age or older?	☐Yes ☐No ☐
2. Are you currently sick or experiencing a high fever?	☐Yes ☐No ☐
3. Do you have any allergies to food, a vaccine component, or latex?	☐Yes ☐No ☐Don't know
4. Have you had a serious reaction to a vaccine in the past?	☐Yes ☐No
5. Have you had a positive COVID-19 test in the last 5 days?	☐Yes ☐No
6. Are you pregnant or breastfeeding, or is there a chance of becoming pregnant during the next month?	☐Yes ☐No ☐Don't know
7. Have you had a dose of COVID-19 vaccine? IF YES, what was the date of your last dose (if known): _____	☐Yes ☐No

- Patients ≥ 12 years of age may receive a single booster dose of the COVID-19 2024-2025 formula (Pfizer or Moderna) **at least 8 weeks after their last COVID-19 vaccine dose.**
- Any patient ≥ 12 years of age who has never received a COVID-19 vaccine may receive a single dose of the COVID-19 2024-2025 formula (Pfizer or Moderna). A booster dose is not recommended after the initial dose is given.

INSURANCE INFORMATION (It is participant's responsibility to verify coverage. Please bring copy of card or card to clinic)

☐ Aetna (NO HCA) ☐ *Aetna Medicare* ☐ Blue Cross (NO NHW, OEG, KWF) ☐ *Blue Cross Medicare*

☐ Cigna (NO EPO Connect, SureFit) ☐ Humana (NO PPOx) ☐ *Humana Medicare* ☐ Luminare (Payer # _____)

☐ Meritain ☐ United All Savers ☐ UnitedHealthcare (NO Core plans) ☐ *UnitedHealthcare Medicare*

☐ UMR/GEHA ☐ *Medicare Part B* ☐ *Railroad Medicare Part B*

*We **cannot** accept all insurances, including: Medicaid, TriCare, and ACA plans such as Ambetter (BCBS ACA plans OK)*

Patient Name (as listed with insurance): _____

Member ID#: _____ Suffix:_____

The acceptance of your health insurance information does not guarantee coverage or payment by your insurance company.
I fully understand that I will be responsible for charges insurance or Medicare does not pay.

OTHER PAYMENT INFORMATION
(to be completed by HS Staff ONLY)

☐ Cash

☐ Check # ____

☐ Venmo

$ Paid: _____

☐ Blue Log
(Employer Paid—see packet for details)

☐ HS Coupon

I have been offered a copy of the Emergency Use Authorization (EUA) for this vaccine I receive today. I have read the information about the COVID-19 vaccine and I have had a chance to ask questions. I understand the benefits and risks of the COVID-19 vaccination and request that the vaccine be given to me or the person named above for whom I am authorized to sign. I agree that Healthy Solutions, Inc. is not responsible or liable if I contract COVID-19, other respiratory diseases, or suffer any other adverse reaction or event following administration of the COVID-19 vaccine. As a condition of receiving the vaccine, I, myself, my heirs and executors hereby waive any right I may have to make a claim against Healthy Solutions, Inc. and the sponsoring organization, their affiliates, divisions, subsidiaries, officers, directors, advisory boards, employees, and contractors from any and all claims arising out of, in connection with, or in any way related to my receiving the COVID-19 vaccine. I authorize Healthy Solutions, Inc. to furnish information to and receive payment from insurance companies for services provided me. I understand that these records may be protected by Federal Regulations and have been offered Healthy Solutions, Inc.'s Notice of Privacy Practices. In order to provide program participation Healthy Solutions, Inc. may provide my name to the sponsoring organization or its designated representative. I agree that Healthy Solutions, Inc., its agents and employees, are not liable if individuals or companies to whom they release information disclose the information without my consent. I accept responsibility for seeking medical attention for any problems associated with my receiving the vaccination. I consent to this immunization data to be submitted to the state registry—to have this information excluded, I can contact immunizations@ballsfoods.com.
I understand it is recommended to stay in the area for 15 minutes following vaccine administration.

Participant Signature_____ Date:_____

(or Legal Guardian if 5 -17 years old, list relationship: _____)

Manufacturer _____

Lot # _____ Exp. _____

Injection Site: ☐ RIGHT ☐ LEFT

Vaccine: ☐ VIAL ☐ PREFILLED

Nurse Signature: _____