SUNRISE URGENT CARE

24948 FM 1093 Suite 205	Richmond, TX 77406
Address	City,State,Zip
281-347-2228	281-371-3366
Telephone	Fax

COVID Vaccine Intake Consent Form

Patient Information

Last Name	First Name	Date of Birth	Gender

Address	City, State, Zip	Phone Number

Screening Questions

Are you feeling sick today (Example: fever, a cold or acute illness)?	**Yes**	No
Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) List:	**Yes**	No
Do you take anticoagulation medication? (For example: warfarin, Coumadin or other blood thinner)	**Yes**	No
Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia or other blood disorder?	**Yes**	No
Do you have cancer, leukemia, HIV/AIDS or any other immune system problem?	**Yes**	No
In the past 3 months, have you taken medications that weaken your immune system such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	**Yes**	No
Have you had a seizure, brain, or other nervous system problem? (For example: Guillain-Barré syndrome)	**Yes**	No
During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	**Yes**	No
For women: Are you pregnant or nursing? Could you become pregnant during the next month?	**Yes**	No
Have you received any vaccinations in the past 4 weeks? If so, when? / /	**Yes**	No
Which age group are you? 5-11yrs old ***OR*** 12yrs & older (circle one)		

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: contact doctor or call 911. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize Sunrise Urgent Care Center to release information *and* request payment. I certify that the information given by me in applying for payment under Medicare or Medicaid, Commercial Health Plans or the HRSA COVID-19 Program for Uninsured Patients, is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

DISCLOSURE OF RECORDS: I understand that Sunrise Urgent Care Center may be required to or may voluntarily disclose my health information to my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that Sunrise Urgent Care Center will use and disclose my health information as set forth in the Sunrise Urgent Care Center's Notice of Privacy Practices.

Signature of patient to receive vaccine (or parent, guardian, or authorized representative)	Date

Name of parent, guardian, or authorized representative	Phone Number	Relationship

For Office Use Only

	COVID-19, mRNA, LNP-S, PF		***Pfizer, Inc.***	
Administration Date	Vaccine	VIS Date	Manufacturer	Volume (mL)
		Intramuscular	*L R*	
Lot #	Expiration Date	Route	Site	