Fair Haven Community Health Care

PFIZER-BIONTECH COVID-19 VACCINE CONSENT FORM

Please complete both sides of the consent form and return it to the school.

Parent/guardian INITIALS required for all questions.

	YES	NO
I give permission for my child to receive the Pfizer-BioNtech COVID-19 vaccine in the School.		
My child may receive the vaccine without a parent/guardian present. If you initial "no," please plan to be present at your child's appointment.		
Does your child have a severe bleeding disorder or are they taking a blood thinner?		
Does your child have a problem with his/her immune system?		
Has your child had any vaccine in the past 14 days?		
Has your child ever had an allergic reaction to a prior dose of the COVID-19 vaccine or to a component of the COVID-19 vaccine, including: • polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures; • polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.		
Has your child ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?		
Has your child ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies and/or do they carry an Epi-Pen for a severe allergy?		
Has your child received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?		
Is your child pregnant or breastfeeding?		

I have read or had explained to me the information in the *Emergency Use Authorization of the Pfizer-BioNtech COVID-19 Vaccine* (https://www.fda.gov/media/144413/download). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of Pfizer-BioNtech COVID-19 vaccine and ask that the vaccine be given to the person named below for whom I am authorized to make this request. I understand that, as with any medical test, procedure, or immunization, there is the potential for adverse reaction(s) or side effects from the vaccine being administered. I authorize FHCHC to record my vaccination administration, to the county, state, or to any other governmental entity as may be required by law.

STUDENT NAME:	**STUDENT DATE OF BIRTH:**
Signature of person authorized to make this request (parent or guardian): **X**_____ **DATE:** _____	
RELATIONSHIP TO STUDENT:	**PHONE NUMBER:**

Fair Haven Community Health Care

COVID VACCINE REGISTRATION FORM

Patient Name

Last Name:	**First Name:**		**Middle Name:**
DOB	**Social Security #**		**Email Address:**
Street Address:	**City:**	**Zip Code:**	**Phone Number:**

Insurance Status

Do you have Medical Insurance?	**Yes**	**No**	**Carrier Name**
Subscriber/Guarantor Name	**Subscriber/Guarantor DOB**		**Relationship to Student**
Policy Number#		**Group#**	

CONSENT FOR TREATMENT: I consent to my child being treated as a patient of Fair Haven Community Health Clinic, Inc. ("FHCHC") for the purpose of receiving care and treatment. All FHCHC services are provided solely on a voluntary basis. I understand and agree that: (i) FHCHC is a Federally Qualified Health Center with a teaching function and students may be involved in observing and giving care unless I disagree; (ii) clinical providers have privileges to practice at FHCHC, but not all clinicians are employees of FHCHC; (iii) I have the right to consent or refuse to consent to any proposed procedure or therapeutic treatment, and that discussion of the risks, benefits and alternatives to each procedure or treatment is available to me; (iv) photographs or other images may be made of me for purposes of clinical documentation as deemed appropriate by my clinician. I understand that these images will be stored in a secure manner that will protect my privacy.
I understand that if FHCHC is not my medical home that I am not creating a patient relationship with FHCHC by participating in the vaccination clinic and I agree to seek medical advice, care and treatment from my medical clinician with additional questions or concerns I may have.

RELEASE OF INFORMATION: I understand that FHCHC can release all necessary health information for purposes of treatment, payment and healthcare operations.

CONSENT TO BILL: I hereby authorize and direct my insurance carrier to pay benefits for services rendered, directly to FHCHC.

COMMUNICATIONS VIA PHONE: If I have provided a telephone number as a primary telephone contact, I hereby authorize FHCHC, along with their respective employees and business associates, to contact me via phone, text message or mobile apps for any reason, including, without limitation, automated notifications and appointment reminders. I know that I am under no obligation to authorize FHCHC to contact me via phone call or text message. I may opt-out of receiving these communications at any time by calling the main line 203-777-7411 and speaking with a Call Center representative.

I certify that the information given above is true to the best of my knowledge.

Signature of Patient or Parent/Guardian: _____ Date: _____