Regional School Unit 1

34 Wing Farm Parkway, Bath, ME 04530

Patrick Manuel, Superintendent
Debra Clark, Business Manager

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Think - Care - Act

RSU 1 COVID-19 Vaccine Clinic
Permission Slip and Transportation Request

Student First and Last Name:

____

Student School (check one):

- ❑ MHS/ BT
- ❑ BMS
- ❑ WCS

Student Age as of May 19th: ________________

Student Grade: ___________________________

For MHS Students Only (please check if true):

- ❑ *Yes, I will need bus transportation to get to the vaccine clinic.*

MID COAST HOSPITAL

COVID-19 VACCINE REGISTRATION FORM

DATE:

NAME

Last: First: Middle Initial: _

CONTACT INFORMATION

Mailing Address:

City: State: ZIP Code:

Home Phone: Cell Phone: Work Phone:

Primary Phone: ☐ Home ☐ Cell ☐ Work Email Address:

PERSONAL INFORMATION

Date of Birth: Age: Gender:

Race: ☐ American Indian ☐ Asian ☐ Native Hawaiian/Pacific Islander

☐ Black/African American ☐ White ☐ Other Race

Ethnicity: ☐ Hispanic ☐ Not Hispanic

PRIMARY CARE PHYSICIAN

Name: Address:

EMPLOYMENT INFORMATION

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed

☐ Unemployed ☐ Active Military ☐ Retired

Employer's Name:

HEALTH INSURANCE INFORMATION

Primary:

Group Number:

ID/Certificate Number:

Subscriber:

Subscriber Date of Birth:

Relationship to Patient:

Secondary:

Group Number:

ID/Certificate Number:

Subscriber:

Subscriber Date of Birth:

Relationship to Patient:

☐ No Insurance

MID COAST HOSPITAL

COVID-19 VACCINE CONSENT FORM

PERSONAL INFORMATION

Last Name: First Name: Middle Initial:

Date of Birth: Age: Gender:

Mailing Address:

City: State: ZIP Code:

Primary Care Physician's Name:

I. **DESCRIPTION, PURPOSE, AND EXPECTED BENEFITS OF VACCINE PROCEDURE.** I understand that I will receive a vaccine by needle injection, which is intended to reduce the chances of my becoming ill due to a COVID-19 infection. COVID-19 infections can have serious, life-threatening complications. Depending upon the particular COVID-19 vaccine, I may require either one or two injections. I agree to remain at the vaccination location for at least 15 minutes after the vaccine is administered so I could be attended to if I had an adverse reaction to the vaccine.

II. **POTENTIAL RISKS AND LIMITATIONS ASSOCIATED WITH THE PROCEDURE.** I understand that I may experience soreness, redness, and/or swelling at the injection site. The other significant known and potential risks and benefits of the vaccine, and the extent to which such risks and benefits are unknown, is described in an FDA Emergency Use Authorization (EUA) Fact Sheet. I have received and read the Fact Sheet and a pre-vaccination checklist for the vaccine. If I have any further questions about the procedure, I will ask them before undergoing the vaccination. It is unclear how long any potential benefits of the vaccine may last; or whether it will be effective against mutating forms of the COVID-19 virus. I understand that I may still become ill with COVID-19, and may be able to transmit the virus to other individuals. **For this reason, the vaccine does not eliminate the need for physical masking, social distancing, and hand hygiene.**

III. **TREATMENT ALTERNATIVES.** I understand that I may refuse the COVID-19 vaccine. There currently are no known effective alternatives to prevent COVID-19 infections, other than physical masking, social distancing, and hand hygiene.

IV. **PRECAUTIONS/CONTRAINDICATIONS.** Vaccine may not be indicated depending on your responses.

Question	No	Yes
Fever or feeling ill today?	☐ **No**	☐ **Yes**: Defer until feeling better.
History of an allergic reaction (e.g. anaphylaxis, hives, or itching) to any component of this vaccine?	☐ **No**	☐ **Yes**: STOP and do NOT vaccinate.
History of any immediate allergic reaction to another vaccine?	☐ **No**	☐ **Yes**: Consult with physician and consider deferral.
History of any immediate allergic reaction to an injectable therapy or IV contrast?	☐ **No**	☐ **Yes**: Consult with physician and consider deferral.
History of anaphylaxis?	☐ **No**	☐ **Yes**: Observe for 30 minutes.

V. **USE OF HEALTH INFORMATION.** I understand that record of this vaccine administration will be reported to the state and/or federal regulatory bodies. I authorize my COVID-19 vaccine record to be shared with my primary care physician; and to be used or shared for payment, quality of care, patient safety, and research purposes. Otherwise, the information will be handled in accordance with the MaineHealth Notice of Health Information Privacy Practices, available online at https://www.mainehealth.org/-/media/Maine-Medical-Center/Files/Psychiatry/Notice-Privacy-Practices-2017.pdf, with printed copies also available on request.

VI. **PHONE CONTACT.** I consent to being contacted by MaineHealth or its agents by telephone (cell or landline), text message, or voice message at the telephone number previously provided. This consent applies to those individuals who are acting on my behalf.

Emergency Contact Name: Emergency Contact Number:

Date Time ☐AM ☐PM X Signature ☐Patient ☐Parent ☐Guardian ☐Authorized Rep. Printed Name

Date Time ☐AM ☐PM X Witness Signature *Phone consent or when patient physically unable to sign* Printed Name

Interpreter: ☐Sign Lang. ☐Foreign Lang. ☐Other: Print Name or ID Information:

FOR STAFF USE ONLY

☐ Identify Confirmed	Vaccine Manufacturer:
Vaccinator Signature:	Lot #: Expiration Date:
Vaccination Date:	Dose: ☐ 1 ☐ 2
☐ Patient **had** an immediate adverse reaction to the vaccine.	Vaccine Administered IM in: ☐ Right Deltoid ☐ Left Deltoid
☐ Patient **did not have** an immediate adverse reaction to the vaccine.	

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name ____________________

Age __________

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product ________			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of a COVID-19 vaccine including either of the following:			
○ 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.			
• A previous dose of COVID-19 vaccine.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you 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.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Form reviewed by ____________________ **Date** __________