

MaineHealth**COVID-19 Vaccine Registration**

Patient First Name	
Patient Middle Initial	
Patient Last Name	
Patient Date of Birth	
Patient (Legal) Gender	
Last 4 Digits of Social Security No.	
Patient Language	
Interpreter Needed (Yes/No)	
Patient Race	
Patient Ethnicity	
Mailing Address: Street Address	
Mailing Address: City	
Mailing Address: State	
Mailing Address: Zip Code	
Mailing Address: County	
Physical Address: If different from mailing address	
Phone Number: Mobile	
Phone Number: Home	
Insurance Identification Number/ Policy Number/ Member ID #	
Insurance Company Name	

Ethnicity:

Hispanic

Non-Hispanic

Unknown

Race:

American Indian or Alaska Native

Asian

Black or African American

Multi-Racial

Native Hawaiian or Other Pacific Islander

White or Caucasian

Unknown

COVID-19 VACCINATION



PATIENT LABEL HERE

- 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 that 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.

Fever or feeling ill today?	<input type="checkbox"/> No or <input type="checkbox"/> Yes – if yes, then defer until feeling better.
History of an allergic reaction (e.g., anaphylaxis, hives, itching) to any component of this vaccine?	<input type="checkbox"/> No or <input type="checkbox"/> Yes – if yes, then STOP, do NOT vaccinate.
History of any immediate allergic reaction to another vaccine?	<input type="checkbox"/> No or <input type="checkbox"/> Yes – if yes, then consult with physician and consider deferral of vaccination.
History of any immediate allergic reaction to an injectable therapy or IV contrast?	<input type="checkbox"/> No or <input type="checkbox"/> Yes – if yes, then consult with physician and consider deferral of vaccination.
History of anaphylaxis?	<input type="checkbox"/> No or <input type="checkbox"/> Yes – if yes, then 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 Phone Number: _____

_____ X
 Date Time AM|PM Signature Patient Parent Guardian Authorized Representative Printed Name
 If by telephone consent given by: Patient Other _____ Phone number _____

_____ X
 Date Time AM|PM Witness Signature (For phone consent or when patient is physically unable to sign) Printed Name
 Interpreter for: Sign Language Foreign Language Other _____ Print Name or identifying information _____

_____ X
 Date Time 24 Hour Signature of Physician or Designee Printed Name

For Staff Use Only:
 Patient had an immediate adverse reaction to the vaccine. Patient did not have an immediate adverse reaction to the vaccine.