WOODSTOCK PUBLIC SCHOOLS

COVID-19 PEDIATRIC 2ND / 1ST DOSE CLINIC
ADULT BOOSTER / FIRST DOSE CLINIC
FRIDAY, DECEMBER 3RD 12:00-5:30 PM
PUTNAM MIDDLE SCHOOL AUDITORIUM LOCATED AT 35 WICKER STREET IN PUTNAM

Dear Woodstock Families,

Woodstock Public Schools will once again join with Putnam and Thompson school districts in hosting a follow up COVID-19 vaccination clinic, as part of our ongoing partnership with Day Kimball Healthcare.

The clinic will be held on Friday, December 3 from 12:00 PM to 5:30 PM at the.

Please note that Friday, December 3 will now be an early dismissal day.

This voluntary clinic will provide families with the opportunity to receive the second or first dose of the newly approved Pediatric COVID-19 vaccine for children ages 5 to 11.

Any adult will also be able to receive a COVID-19 Booster or their first shot during the clinic. Remember it's never too late to get vaccinated.

Consent forms will be made available onsite and please remember to bring an insurance card, ID and your vaccination card if you are receiving a booster shot.

The Connecticut State Department of Education in partnership with the Connecticut Department of Public Health have encouraged all school districts to work closely with their local healthcare agencies in providing vaccine clinics for families. Day Kimball Healthcare continues to be a valued partner in helping to keep our community healthy.

Sincerely,

V. Toth

Viktor Toth
Superintendent of Schools

Viktor Toth
Superintendent of Schools
tothv@woodstockschools.net

Woodstock, Connecticut 06281
Telephone: 860.928.7453
Fax: 860.928.0206

DKH DAY KIMBALL HEALTHCARE
Day Kimball Hospital | 320 Pomfret Street Putnam, CT 06260

NAME: _____ DATE OF BIRTH: _____

PFIZER COVID-19 VACCINE CONSENT FORM

PEDIATRIC

	Yes	No
Is your child 5 to 11 years of age?	☐	☐
Is your child currently sick with a fever or infection?	☐	☐
Does your child have a bleeding disorder or is on a blood thinner?	☐	☐
Does your child have any allergies or had a severe allergic reaction after a previous dose of this vaccine?	☐	☐
Is your child immunocompromised or on a medicine that affects his/her immune system?	☐	☐
Has your child received another COVID-19 vaccine other than Pfizer?	☐	☐
I attest to my child meeting the criteria for the Pfizer Booster.	☐	☐
Has your child ever had a reaction to any of the ingredients in the Pfizer COVID-19 vaccine which include: messenger ribonucleic acid (mRNA), lipids (((4-hydroxybutyl)azanediyl)bis(hexane-6.1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-distearoyl-sn-glycero-3-phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose	☐	☐

I have read or have had explained to me the current Fact Sheet for Recipients and Caregivers, Emergency Use Authorization of the Pfizer-BioNTech Pediatric COVID-19 Vaccine dated 10/29/21. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the COVID-19 vaccine and ask that the vaccine be administered to my child.

_____ _____ _____

Parent/Legal Guardian Signature **Date** **Time**

PLEASE COMPLETE DEMOGRAPHICS ON BACK

For Vaccinator to complete:

Vaccine: Pfizer-BioNTech Pediatric COVID-19 Vaccine ☐ Dose #1 (0.2ml) ☐ Dose #2 (0.2ml)

Lot#: _____ **Exp.** _____ **Site:** _____ deltoid

Administered by:_____**Date**:_____ **Time**:_____

PLEASE PRINT:

NAME: _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE NUMBER: _____

GENDER: _____

ETHNICITY/RACE: _____

SCHOOL: _____

Insurance Policy Holder's Information

PLEASE PRINT:

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DATE OF BIRTH_____

INSURANCE COMPANY (i.e., Anthem, Blue Cross, ConnectiCare)**:** _____

ID#:_____ **POLICY #:** _____ **GROUP#:**_____

EMPLOYER: _____

If different from above:

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE NUMBER: _____

VACCINE INFORMATION FACT SHEET FOR RECIPIENTS AND CAREGIVERS ABOUT THE PFIZER-BIONTECH COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) FOR USE IN INDIVIDUALS 5 THROUGH 11 YEARS OF AGE

FOR 5 THROUGH 11 YEARS OF AGE

Your child is being offered the Pfizer-BioNTech COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2.

This Vaccine Information Fact Sheet for Recipients and Caregivers comprises the Fact Sheet for the authorized Pfizer-BioNTech COVID-19 Vaccine for use in individuals 5 through 11 years of age.[1]

The Pfizer-BioNTech COVID-19 Vaccine has received EUA from FDA to provide a two-dose primary series to individuals 5 through 11 years of age.

This Vaccine Information Fact Sheet contains information to help you understand the risks and benefits of the Pfizer-BioNTech COVID-19 Vaccine, which your child may receive because there is currently a pandemic of COVID-19. Talk to your child's vaccination provider if you have questions.

This Fact Sheet may have been updated. For the most recent Fact Sheet, please see www.cvdvaccine.com.

WHAT YOU NEED TO KNOW BEFORE YOUR CHILD GETS THIS VACCINE

WHAT IS COVID-19?

COVID-19 disease is caused by a coronavirus called SARS-CoV-2. You can get COVID-19 through contact with another person who has the virus. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness leading to death. Symptoms may appear 2 to 14 days after exposure to the virus. Symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

For more information on EUA, see the "**What is an Emergency Use Authorization (EUA)?**" section at the end of this Fact Sheet.

[1] You may receive this Vaccine Information Fact Sheet even if your child is 12 years old. Children who will turn from 11 years to 12 years of age between their first and second dose in the primary regimen may receive, for either dose, either: (1) the Pfizer-BioNTech COVID-19 Vaccine formulation authorized for use in individuals 5 through 11 years of age; or (2) COMIRNATY or one of the Pfizer-BioNTech COVID-19 Vaccine formulations authorized for use in individuals 12 years of age and older.

WHAT SHOULD YOU MENTION TO YOUR CHILD'S VACCINATION PROVIDER BEFORE YOUR CHILD GETS THE VACCINE?

Tell the vaccination provider about all of your child's medical conditions, including if your child:

- has any allergies
- has had myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside the heart)
- has a fever
- has a bleeding disorder or is on a blood thinner
- is immunocompromised or is on a medicine that affects your child's immune system
- is pregnant
- is breastfeeding
- has received another COVID-19 vaccine
- has ever fainted in association with an injection

HOW IS THE VACCINE GIVEN?

The Pfizer-BioNTech COVID-19 Vaccine will be given to your child as an injection into the muscle.
The vaccine is administered as a 2-dose series, 3 weeks apart.
The vaccine may not protect everyone.

WHO SHOULD NOT GET THE VACCINE?

Your child should not get the vaccine if your child:

- had a severe allergic reaction after a previous dose of this vaccine
- had a severe allergic reaction to any ingredient of this vaccine.

WHAT ARE THE INGREDIENTS IN THE VACCINE?

The vaccine includes the following ingredients: mRNA, lipids ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-Distearoyl-sn-glycero-3-phosphocholine, and cholesterol), tromethamine, tromethamine hydrochloride, sucrose, and sodium chloride.

HAS THE VACCINE BEEN USED BEFORE?

Millions of individuals 12 years of age and older have received the Pfizer-BioNTech COVID-19 Vaccine under EUA since December 11, 2020. In a clinical trial, approximately 3,100 individuals 5 through 11 years of age have received at least 1 dose of Pfizer-BioNTech COVID-19 Vaccine. In other clinical trials, approximately 23,000 individuals 12 years of age and older have received at least 1 dose of the vaccine. The vaccine that is authorized for use in children 5 through 11 years of age includes the same mRNA and lipids but different inactive ingredients compared to the vaccine that has been used under EUA in individuals 12 years of age and older and that has been studied in clinical trials. The use of the different inactive ingredients helps stabilize the vaccine under refrigerated temperatures and the formulation can be readily prepared to deliver appropriate doses to the 5 through 11 year-old population.

WHAT ARE THE BENEFITS OF THE VACCINE?
The vaccine has been shown to prevent COVID-19.

The duration of protection against COVID-19 is currently unknown.

WHAT ARE THE RISKS OF THE VACCINE?
There is a remote chance that the vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the vaccine. For this reason, your child's vaccination provider may ask your child to stay at the place where your child received the vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include:

- Difficulty breathing
- Swelling of the face and throat
- A fast heartbeat
- A bad rash all over the body
- Dizziness and weakness

Myocarditis (inflammation of the heart muscle) and pericarditis (inflammation of the lining outside the heart) have occurred in some people who have received the vaccine. In most of these people, symptoms began within a few days following receipt of the second dose of vaccine. The chance of having this occur is very low. You should seek medical attention right away if your child has any of the following symptoms after receiving the vaccine:

- Chest pain
- Shortness of breath
- Feelings of having a fast-beating, fluttering, or pounding heart

Side effects that have been reported with the vaccine include:

- severe allergic reactions
- non-severe allergic reactions such as rash, itching, hives, or swelling of the face
- myocarditis (inflammation of the heart muscle)
- pericarditis (inflammation of the lining outside the heart)
- injection site pain
- tiredness
- headache
- muscle pain

- chills
- joint pain
- fever
- injection site swelling
- injection site redness
- nausea
- feeling unwell
- swollen lymph nodes (lymphadenopathy)
- decreased appetite
- diarrhea
- vomiting
- arm pain
- fainting in association with injection of the vaccine

These may not be all the possible side effects of the vaccine. Serious and unexpected side effects may occur. The possible side effects of the vaccine are still being studied in clinical trials.

WHAT SHOULD I DO ABOUT SIDE EFFECTS?
If your child experiences a severe allergic reaction, call 9-1-1, or go to the nearest hospital.

Call the vaccination provider or your child's healthcare provider if your child has any side effects that bother your child or do not go away.

Report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS). The VAERS toll-free number is 1-800-822-7967 or report online to https://vaers.hhs.gov/reportevent.html. Please include "Pfizer-BioNTech COVID-19 Vaccine EUA" in the first line of box #18 of the report form.

In addition, you can report side effects to Pfizer Inc. at the contact information provided below.

Website	Fax number	Telephone number
www.pfizersafetyreporting.com	1-866-635-8337	1-800-438-1985

You may also be given an option to enroll in v-safe. V-safe is a new voluntary smartphone-based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after COVID-19 vaccination. V-safe asks questions that help CDC monitor the safety of COVID-19 vaccines. V-safe also provides second-dose reminders if needed and live telephone follow-up by CDC if participants report a significant health impact following COVID-19 vaccination. For more information on how to sign up, visit: www.cdc.gov/vsafe.

WHAT IF I DECIDE NOT TO HAVE MY CHILD GET THE PFIZER-BIONTECH COVID-19 VACCINE?
Under the EUA, there is an option to accept or refuse receiving the vaccine. Should you decide for your child not to receive it, it will not change your child's standard medical care.

ARE OTHER CHOICES AVAILABLE FOR PREVENTING COVID-19 BESIDES PFIZER-BIONTECH COVID-19 VACCINE?
For children 5 through 11 years of age, there are no other COVID-19 vaccines available under Emergency Use Authorization and there are no approved COVID-19 vaccines.

CAN MY CHILD RECEIVE THE PFIZER-BIONTECH COVID-19 VACCINE AT THE SAME TIME AS OTHER VACCINES?
Data have not yet been submitted to FDA on administration of the Pfizer-BioNTech COVID-19 Vaccine at the same time with other vaccines. If you are considering to have your child receive the Pfizer-BioNTech COVID-19 Vaccine with other vaccines, discuss the options with your child's healthcare provider.

WHAT ABOUT PREGNANCY OR BREASTFEEDING?
If your child is pregnant or breastfeeding, discuss the options with your healthcare provider.

WILL THE VACCINE GIVE MY CHILD COVID-19?
No. The vaccine does not contain SARS-CoV-2 and cannot give your child COVID-19.

KEEP YOUR CHILD'S VACCINATION CARD
When your child gets the first dose, you will get a vaccination card to show when to return for your child's next dose(s) of the vaccine. Remember to bring the card when your child returns.

ADDITIONAL INFORMATION
If you have questions, visit the website or call the telephone number provided below.

To access the most recent Fact Sheets, please scan the QR code provided below.

Global website	Telephone number
www.cvdvaccine.com	1-877-829-2619 (1-877-VAX-CO19)

HOW CAN I LEARN MORE?

- Ask the vaccination provider.
- Visit CDC at https://www.cdc.gov/coronavirus/2019-ncov/index.html.
- Visit FDA at https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization.
- Contact your local or state public health department.

WHERE WILL MY CHILD'S VACCINATION INFORMATION BE RECORDED?

The vaccination provider may include your child's vaccination information in your state/local jurisdiction's Immunization Information System (IIS) or other designated system. This will ensure that your child receives the same vaccine when your child returns for the second dose. For more information about IISs visit: https://www.cdc.gov/vaccines/programs/iis/about.html.

CAN I BE CHARGED AN ADMINISTRATION FEE FOR RECEIPT OF THE COVID-19 VACCINE?

No. At this time, the provider cannot charge you for a vaccine dose and you cannot be charged an out-of-pocket vaccine administration fee or any other fee if only receiving a COVID-19 vaccination. However, vaccination providers may seek appropriate reimbursement from a program or plan that covers COVID-19 vaccine administration fees for the vaccine recipient (private insurance, Medicare, Medicaid, Health Resources & Services Administration [HRSA] COVID-19 Uninsured Program for non-insured recipients).

WHERE CAN I REPORT CASES OF SUSPECTED FRAUD?

Individuals becoming aware of any potential violations of the CDC COVID-19 Vaccination Program requirements are encouraged to report them to the Office of the Inspector General, U.S. Department of Health and Human Services, at 1-800-HHS-TIPS or https://TIPS.HHS.GOV.

WHAT IS THE COUNTERMEASURES INJURY COMPENSATION PROGRAM?

The Countermeasures Injury Compensation Program (CICP) is a federal program that may help pay for costs of medical care and other specific expenses of certain people who have been seriously injured by certain medicines or vaccines, including this vaccine. Generally, a claim must be submitted to the CICP within one (1) year from the date of receiving the vaccine. To learn more about this program, visit www.hrsa.gov/cicp/ or call 1-855-266-2427.

WHAT IS AN EMERGENCY USE AUTHORIZATION (EUA)?

An Emergency Use Authorization (EUA) is a mechanism to facilitate the availability and use of medical products, including vaccines, during public health emergencies, such as the current COVID-19 pandemic. An EUA is supported by a Secretary of Health and Human Services (HHS) declaration that circumstances exist to justify the emergency use of drugs and biological products during the COVID-19 pandemic.

The FDA may issue an EUA when certain criteria are met, which includes that there are no adequate, approved, available alternatives. In addition, the FDA decision is based

on the totality of scientific evidence available showing that the product may be effective to prevent COVID-19 during the COVID-19 pandemic and that the known and potential benefits of the product outweigh the known and potential risks of the product. All of these criteria must be met to allow for the product to be used in the treatment of patients during the COVID-19 pandemic.

This EUA for the Pfizer-BioNTech COVID-19 Vaccine will end when the Secretary of HHS determines that the circumstances justifying the EUA no longer exist or when there is a change in the approval status of the product such that an EUA is no longer needed.

Manufactured by
Pfizer Inc., New York, NY 10017

Manufactured for
BioNTech Manufacturing GmbH
An der Goldgrube 12
55131 Mainz, Germany

LAB-1486-0.3

Revised: 29 October 2021

Scan to capture that this Fact Sheet was provided to vaccine recipient for the electronic medical records/immunization information systems.

Barcode Date: 09/30/2021

DAY KIMBALL HOSPITAL **Name: _____**

320 Pomfret Street, Putnam, CT 06260 **MR # _____**

AUTHORIZATION FOR BASIC TREATMENT CONDITIONS OF ADMISSION

INTRODUCTION:

This is an agreement between you and Day Kimball Hospital (the "Hospital"). It contains your agreement to pay for all services you will receive from the Hospital. It also addresses the use of your medical records (and other information about "you", "your"), insurance benefits, and certain conditions in regard to your treatment and stay at the Hospital. In consideration of receiving services, you agree as follows:

AUTHORIZATION TO PROVIDE BASIC TREATMENT AND CONDUCT BASIC AND ROUTINE DIAGNOSTIC PROCEDURES:

I authorize the performing of all routine examinations, treatments, and care provided to me under the general or specific Instructions or direction of my physician or Hospital staff. I consent to being admitted/treated as a patient of Day Kimball Healthcare and for the purpose of receiving medical care and treatment and/or diagnostic procedures. I understand that the institution and its contracted clinicians may use audio/video monitoring and consultation to enhance my care in some locations or video monitoring for patient safety.

Pursuant to Public Act 09-133, I understand that as part of the medical procedures or tests, I may be tested for HIV. I understand that HIV testing is voluntary and I can choose not to be tested for HIV or antibodies to HIV.

INFORMED CONSENT:

I understand that if I require an operation or any procedure involving a degree of risk requiring an informed consent, except in the event of emergency my own physician will discuss the risks, benefits, and alternatives and answer my questions. I am entitled to consent or refuse to consent.

MY PHYSICIAN(S) MAY BE AN INDEPENDENT CONTRACTOR:

I understand that many physicians furnishing services to me including but not limited to radiologists, pathologists and Emergency Department physicians are independent contractors and not employees or agents of the Hospital. I also understand that if I have any questions concerning the status of any health care provider as an independent contractor, employee or agent, I can ask questions. I also understand that the independent contractors occasionally wear white coats or other hospital garb and identification badges required by the Hospital, but that the use of this clothing or the use of a hospital identification badge is not intended to lead anyone to believe that the person using the clothing or the identification badge is an employee or agent of the Hospital.

RELEASE OF MEDICAL RECORDS AND OTHER INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS:

I authorize the hospital to provide from its records any information and medical records including psychiatric, substance abuse, HIV related or other confidential information ("Confidential Information") requested by my insurance/managed care company, Medicare, Medicaid, Champus, or other third party payors, hospital agents or governmental agencies in connection with payment of my bill. I also authorize the Hospital and its agents to provide Confidential Information from my medical records to any utilization, managed care, and/or quality review organization affiliated with my insurer/payor or otherwise for use in utilization management. I further authorize the Hospital to provide Confidential Information to its case management personnel, including authorization to discuss my medical care with my physicians, and to other health providers and facilities involved in discharge planning or in my continuing care after hospital discharge. I also authorize the release of Confidential Information to state or federal agencies for authorized purposes.

I have been informed that my refusal to grant consent to release of information relating to psychiatric treatment will not jeopardize my right to obtain present or future treatment except where disclosure of the communication and record is necessary for treatment. I understand that if my refusal to provide authorization results in a refusal of my insurer, managed care company or the third party payor to pay the Hospital, I will personally be responsible for the bill or the unpaid portion of the bill.

ASSIGNMENT OF BENEFITS:

I authorize third party payors, including insurers, managed care companies, and Medicare or Medicaid and other governmental payors, to make payment directly to Day Kimball Hospital, its affiliates, and any physicians involved in my care for medical expenses and any/all (Group or Direct) Hospital benefits otherwise payable to me. I understand that I am financially responsible for payment for services not covered by this authorization, and that I will pay all costs of collection of any delinquent balance including reasonable attorney's fees, which may be added to my account. I understand that my refusal to grant authorization to my third party payors will in no way jeopardize my right to obtain present or future treatment except where disclosure is necessary for treatment, but understand that under such circumstances I will be responsible for paying my bill in full. Upon request, patients may receive copies of their hospital charges. A Patient Advisor is available at 860-928-6541 (ext. 2219 or 3316), should assistance be needed.

CONSENT TO RELEASE OF SOCIAL SECURITY NUMBER TO TRACK MEDICAL DEVICES:
If in the course of my treatment I receive a medical device(s) that is traceable to its manufacturer, I authorize the release of my Social Security number to the manufacturer or its agent. I understand that the hospital has been told that my Social Security number may be used by the manufacturer to attempt to locate me if necessary in regard to this medical device.

PERSONAL VALUABLES:
I understand and agree that the Hospital maintains a safe for the safekeeping of money and valuables. I agree that if I choose not to place valuables in the Hospital safe, the Hospital will not be responsible for the loss of, or damage to my valuables. The Hospital shall not be responsible for loss or damage to items including documents, cash, dental work or dental prosthetics, eyeglasses, credit cards, hearing aids, and items of unusual value or size that have not or cannot be placed in the Hospital safe. I have been advised that any personal valuables should be given to a family member or friend for safekeeping. With the exception of items placed in the Hospital safe and for which a receipt has been issued, I agree not to make any claims against and release Day Kimball Hospital and its staff from any and all liability for any loss or damage that may occur to my personal valuables.

PATIENT RIGHTS AND RESPONSIBILITIES AND NOTICE OF PRIVACY PRACTICES:
The Hospital's Policy on Patient Rights and Responsibilities has been provided to me, and I agree to comply with such policy. Day Kimball Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a language other than English, are deaf or hard of hearing, language assistance services are provided free of charge. Call (860) 928-6541 ext. 2342 or ext. 2229; for TTY, dial 711 and ask to be connected to (860) 928-6541 ext. 2342 or ext. 2229.

FINANCIAL AGREEMENT:
I understand I am responsible for payment of any charges and agree to pay the hospital the regular rates or charges for all hospital and medical services rendered to me. If I am covered by a third party (for example, Blue Cross & Blue Shield or other insurance or managed care, or a benefit program such as Medicare or Medicaid), then the third party may pay all or a part of the hospital rates or charges. If so, I agree to pay those rates or charges that are not covered or paid by that third party, and to the extent permitted by law are properly payable by me, as soon as I receive a bill. If I do not pay my bill I agree to pay the hospital any collection costs including attorney's fees, collection agency fees, and court costs. The hospital reserves the right to accept periodic installment payments without waiving its rights to demand payment in full. If I do not agree, I understand a consultation with our Patient Advisor is required before non-emergent services will be rendered.

MEDICARE AND OTHER GOVERNMENTAL PROGRAMS:
I agree that the information I have given in applying for benefits under Medicare, Medicaid, Maternal or Child Health Services or other governmental programs is complete and accurate. The hospital may give the appropriate state and/or federal agencies (including but not limited to, the State Department of Social Services and the federal Social Security Administration or its fiscal intermediaries), any information about me that I have that may be necessary to process claims for such payment. The hospital, and the doctors and allied health care providers treating me may make direct claims for payment.

VETERANS:
Please indicate if you or your spouse is a veteran of the US Armed Forces. State the name of your spouse if he/she is a veteran. Please identify the branch of the Armed Forces and state the appropriate dates of service:

_____

I HAVE READ THIS PATIENT AGREEMENT, OR IT HAS BEEN READ TO ME, AND I UNDERSTAND IT, ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION, AND I FREELY AGREE TO ALL OF THE TERMS AND CONDITIONS IN THE AGREEMENT THAT ARE APPLICABLE TO THE PATIENT EXCEPT THOSE SPECIFICALLY NOTED ABOVE BY ME AS NOT APPLYING.

****

DATE: _____ **TIME:** _____

X _____

SIGNATURE OF PATIENT

PRINT PATIENT NAME: _____

_____

SIGNATURE OF AUTHORIZED PERSONAL REPRESENTATIVE:

If a representative has signed for the patient, please state the relationship to the patient and the reason the patient did not sign:

_____

If telephone consent:

Obtained from: _____ Date: _____ Time: _____ Relationship: _____

Witness: _____ Date: _____ Time: _____ R.N.(witness) _____ Date: _____ Time: _____