BEDFORD FAMILY HEALTH CENTER
A Division of HAHC, Inc.

Patient Information

Patient First Name:_____ Patient Middle Initial ___ Patient Last Name: _____

Mother's Maiden Name: _____ DOB __/__/____ Gender:☐ Male ☐Female ☐Other Ethnicity: Hispanic?☐ Yes ☐No

Race: ☐American Indian or Alaska Native ☐Asian ☐Black/African-American ☐Native Hawaiian and Pacific Islander ☐White ☐Some Other Race

County of Residence:_____

Address: _____ City: _____ State: _____ ZipCode: _____

Email Address:_____ Phone #:_____ ☐Mobile ☐Landline

Occupation Information

County of Work:_____ Employer: _____

Please check the occupation that best describes your work:

☐ Police/Fire/EMS

☐ Healthcare Personnel - caring for COVID patients

☐ Long Term Care, Skilled Nursing, and Personal Care Home Workers

☐ Healthcare Personnel with direct patient contact

☐ Healthcare Personnel with NO direct patient contact

☐ Public Health Worker

☐ Office manager, supervisor, employee, clerical

☐ Plant worker, manufacturing, machine operators and assemblers

☐ Education – teacher, school staff or contractor

☐ Service – restaurants, bars, catering, food service, fast food

☐ Service - Rental, Cosmetology, Massage, Elective Services

☐ Service – Transportation

☐ Service - Entertainment, Performance

☐ Skilled agricultural, forestry and fishery workers

☐ Utilities- water/energy/waste worker

☐ Childcare / Daycare

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Insurance and Health

Type of Insurance: _____ Insurance Company Name: _____

Member ID Number: _____ Group Number: _____

Policy Holder First Name: _____ Policy Holder Last Name: _____

Insured Adult's Date of Birth _____ Relationship to Patient (Self, Spouse, Other) _____

Patient Consent – COVID-19 Vaccine

Emergency contact name: _____ Emergency contact number: _____

Emergency contact relationship: ☐ spouse ☐ parent ☐ guardian

Please Check Yes or No to ALL of the questions below:

	Yes	No
Are you (or they, if completing for your child or someone else) 18 years of age and older?	☐	☐
Are you (or they, if completing for your child or someone else) sick today?	☐	☐
Do you (or they, if completing for your child or someone else) have any medical conditions, including allergies, fever, bleeding disorder or on a blood thinner, immunocompromised or on a medicine that affects your immune system?	☐	☐
Are you pregnant or plan to become pregnant, or are currently breastfeeding?	☐	☐
Have you received the COVID vaccine previously?	☐	☐
Have you (or if completing for your child or someone else) had a severe allergic reaction after a previous dose of this vaccine?	☐	☐

By signing this form, I request and voluntarily consent for the COVID-19 vaccine to be administered to _____ (self or name of child or whom I am the Parent/Legal Guardian) and a record of the vaccination be entered into a databased for use to monitor the administration of the vaccine and the control of the disease. Further, I agree that the information above is correct, and: (i) I have been given the U.S. Food and Drug Administration's Emergency Use Authorization (EUA) Fact Sheet For Recipients and Caregivers (Fact Sheet); (ii) I understand the risks and benefits of being administered the COVID-19 vaccine and that possible side effects, warnings, and precautions should be considered prior to the administration of the vaccine; (iii) any questions I had about the COVID-19 vaccine and the EUA Fact Sheet have been answered; and (iv) I acknowledge that no guarantees have been made concerning the vaccine's success.

Signature:_____ Please check: ☐ Self ☐ Parent ☐ Legal Guardian Date: _____

Your portion of the consent form is now complete. Please print and bring with you or complete onsite.
Thank you!

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For Clinic Staff Use Only

Vaccine	Vaccine Manufacturer	Lot Number	Dosage	Route (left or right arm)	Site/ Dosage	Date Administered	Signature of Vaccinator
COVID-19	Moderna		1st or 2nd		IM / 0.5 ml		