SAVING LIVES CENTER FAMILY CLINIC & URGENT CARE
3 HILLCREST DR., SUITE A101
FREDERICK, MARYLAND 21703
TEL: 240-575-9940, FAX: 240-575-9481

Patient Information Sheet

Date: _____

NAME: Last _____ **First** _____ **MI** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

DATE OF BIRTH: _____ **Gender: (circle one) Female Male**

RACE: (Please circle one) CAUCASIAN AFRICAN AMERICAN HISPANIC

OTHER_____ INDIAN NATIVE AMERICAN ASIAN

PHONE: (_____) _____- _____ (cell or house phone) (circle one)

How did you hear about us? _____

I acknowledge that all information supplied by myself to Saving Lives Center Family Clinic & Urgent Care is true and correct: _____ (**Patient Initials**)

Fever or feeling ill today?	☐ **No**	☐ **Yes – Defer until feeling better.**
Have you ever received a dose of COVID-19 vaccine?	☐ **No**	☐ **Yes – Ensure same vaccine and appropriateinterval**
History of severe allergic reaction (e.g., anaphylaxis) to any component of this vaccine?	☐ **No**	☐ **Yes – STOP. Do NOT vaccinate.**
History of severe allergic reaction (e.g., anaphylaxis) to another vaccine (not including this vaccine)?	☐ **No**	☐ **Yes – Defer – consult with your primary careprovider.**
History of severe allergic reaction (e.g., anaphylaxis) to an injectable therapy?	☐ **No**	☐ **Yes – Defer – consult with your primary careprovider.**
History of other serious allergic reaction (e.g., anaphylaxis) due to any cause	☐ **No**	☐ **Yes – Requires 30 min observation.**
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐ **No**	☐ **Yes – STOP. Do NOT vaccinate for 90 days fromlast treatment date.**
Have you received another vaccine in the last 14 days?	☐ **No**	☐ **Yes – STOP. Do NOT vaccinate for 14 days fromlast vaccination date.**
Do you have a weakened immune system caused bysomething such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐ **No**	☐ **Yes – Defer – consult with your primary careprovider.**
Are you pregnant or breastfeeding?	☐ **No**	☐ **Yes – Defer – consult with your primary careprovider.**

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INFORMED CONSENT FOR COVID-19 VACCINATION

Authorization and Consent for Covid-19 Vaccination:

The U.S Food and Drug Administration (FDA) has issued an emergency use authorization (EUA) for a vaccine to prevent COVID-19. An emergency use authorization is not the same as full FDA approval of the vaccine, and there is currently not enough scientific evidence available for the FDA to fully approve this or any other COVID-19 vaccine. Like all medications, no vaccine is completely effective, and it takes a few weeks after the vaccine for the body to build up protection. Some people may still get COVID-19 despite having a vaccination, but this vaccine may lessen the severity of any infection. The vaccine cannot give a person COVID-19 and receiving the complete vaccine and the recommended doses will reduce the chance of an individual becoming seriously ill or dying. A vaccinated individual will still need to follow CDC guidelines to reduce the transmission of COVID-19, such as washing hands frequently, keeping social distance, and wearing a face mask when necessary. Like all medications, vaccines can cause side effects. Mos of these are mild a short-term, and not everyone will experience them.

- I have been informed that I am at risk of acquiring COVID-19 because of the nature of my professional responsibilities or the professional responsibilities of my co-workers.
- I understand that consent for this vaccine is voluntary. I have the option to accept or refuse administration of the COVID-19 vaccine.
- I have received and read the COVID-19 vaccination information provided to me, which lists the indications, benefits, presently known side effects, and potential adverse reactions of the COVID-19 vaccine. I have had an opportunity to ask questions and have them answered to my satisfaction.
- I understand that a series of two vaccines will be might require depending on the type of vaccine administered.
- I understand and agree to comply with any additional follow-up dose recommendations of the COVID-19 vaccine.
- I understand that, as with all vaccinations, there is no guarantee that I will become immune to COVID-19 or that I will not experience an adverse side effect or reaction from the COVID-19 vaccine.
- I understand that there is a lack of long-term data on the health effects of the COVID-19 vaccine, and I do understand that there may be certain risks in receiving the COVID-19 vaccine.
- I understand that the FDA has authorized the use of the COVID-19 vaccine under an Emergency Use Authorization (EUA) and that I nonetheless request and consent to the vaccine being given to me.
- I agree to remain on site for 15 minutes after the vaccination and that my condition may warrant post vaccination observation for at least 30 minutes.
- I also understand that in receiving the vaccine, there are many benefits to receiving the COVID-19 vaccine, both for myself, my family, my friends, my co-workers, and the patients I serve.
- I further understand that not getting a COVID-19 vaccine substantially increases the likelihood that I may contract COVID-19.
- By signing, I release SAVING LIVES CENTER LLC and Saving Lives Center Family Clinic & Urgent Care from all liability relating to injuries that may occur during vaccine administration.
- I agree to hold SAVING LIVES CENTER LLC and Saving Lives Center Family Clinic & Urgent Care entirely Free from any liability, including any financial responsibility for injuries or any complications that may arise from the vaccine administration.
- By signing below, I understand all these terms and I forfeit all right to bring suit against SAVING LIVES CENTER LLC and Saving Lives Center Family Clinic & Urgent Care or any of their employees for any reason.

I understand and acknowledge record of this vaccine administration to me will be reported to the state and/or federal regulatory bodies in compliance with reporting for inventory management and use of National Stockpile vaccine supply. I agree and authorize my COVID-19 vaccine record to be shared with my primary care physician and included

in my health record(s) for continuity of care of care purposes. I further agree and authorize my COVID-19 vaccine

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record to be shared for quality of care, patient safety, and other research purposes. In full understanding of the risks that may be involved in receiving the COVID-19 vaccination, I acknowledge that I am an adult who can legally consent for the name below to receive the COVID-19 vaccine. I freely and voluntarily give my signed permission for this vaccine to be given.

Today's Date:_____/_____/_____	Patient Name (Print): _____
Patient / Parent / Guardian Signature; if parent / guardian, please also print name /	
DOB:_____/_____/_____	

Medical Insurance Information

Insurance name:	**Policy Holder's Name**	**Policy Holder's Relationship to Patient**
Subscriber #:	**Group #:**	
Secondary Insurance If applicable		
Insurance name:	**Policy Holder's Name**	**Policy Holder's Relationship to Patient**
Subscriber #:	**Group #**	

*****FOR UNINSURED/No Medical insurance initials_____**

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment. The above information is true to the best of my knowledge. If qualified, I authorize billing to my insurance company and release of information required to process my claims. I authorize my insurance benefits be paid directly to Saving Lives Center Family Clinic & Urgent Care.

_____ _____
Signature of Patient /Responsible Party Date

_____ _____
Name of Patient/Responsible Party(please print) Relationship to Patient

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----------STOP: FOR INTERNAL USE ONLY----------

☐ Dose 1 of 2 administered	☐ Dose 2 of 2 administered(series complete)	☐ Dose 1 of 1 administered(series complete)
☐ Booster	☐ others	☐ others
Vaccine Manufacturer: Lot #: Expiration Date:	Intramuscular Injection Given: ☐ Left Deltoid ☐ Right Deltoid	
Administered By (Full name and Title):	Date of Vaccine:	
☐ Pfizer EUA Given to Patient	☐ Moderna EUA Given to Patient	☐ J&J EUA Given to Patient

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