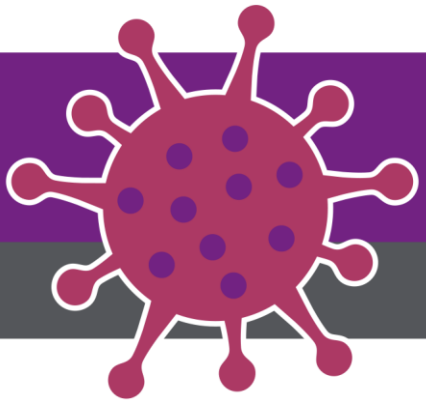
CORONA**VI**RUS **DI**SEASE 2019
(COVID-19)

This document is part of the COVID-19 Vaccine Operations Guidebook



Trinity Health

Audience: Colleagues
Revision Date: 11-2-21
Version: #2
COVID-19 Response Team Owner: Vaccine Operations Workgroup
Date of Last Review: 11-2-21

PROCESS – Part 1 – Registration, Acknowledgment & Consent Form

What's changed – Changed ******PFIZER COVID-19 Vaccine ONLY**** PATIENTS WHO ARE 12 to 17 YEARS OF AGE to PATIENTS WHO ARE 5 to 17 YEARS OF AGE**

Patient label affix

Health Ministry logo here

COVID-19 VACCINE ACKNOWLEDGEMENT

I was provided the Fact Sheet for Recipients for the COVID-19 vaccine I am receiving. I read and/or had explained to me the information provided about the vaccine. I was given the chance to ask questions and any questions I had were answered to my satisfaction. I understand the risks and benefits of the vaccination and I am voluntarily choosing to get the vaccination.

I understand I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. If I have had a previous reaction to a vaccine, I will be monitored for 30 minutes. I understand if I experience any side effects after leaving the vaccination area or an outpatient area I should call my doctor, or if the side effects are severe, I should call 911. I understand if I experience any side effects after receiving a vaccine administration while admitted to the hospital I will notify a healthcare personnel.

AUTHORIZATION FOR PAYMENT

I authorize release of my personal, billing and medical information to third party payers, insurance companies or review agencies for use in connection with payment, including eligibility for payment, regulatory or accreditation compliance or as is required for provider to receive payment or reimbursement for care. I authorize and irrevocably assign to the administrator of the vaccine payment of any benefits payable to me/amounts payable for the vaccine I receive.

DISCLOSURE OF RECORDS

I understand Trinity Health may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated by Trinity Health, my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state/federal registries, for purposes of treatment, payment or other health care operations. I also understand that Trinity Health will use and disclose my health information as set forth in the ministry Notice of Privacy Practices (a copy is available upon request).

I agree that Trinity Health and its business associates may contact me by any phone number provided by me or associated with my health record, including cell phone numbers, which could result in charges to me. Trinity Health also may contact me by sending text messages or emails, using the contact information I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device.

_____ _____

Signature of Patient/Legally Authorized Representative | Date | Time

_____ _____

Printed Name of Patient/Legally Authorized Representative, if applicable | Relationship to Patient, if applicable

---

******PFIZER COVID-19 Vaccine ONLY******
PATIENTS WHO ARE 5 to 17 YEARS OF AGE

I consent for Trinity Health to provide the Pfizer COVID-19 vaccine to the patient identified above. I acknowledge I read this document as well as the Fact Sheet for Vaccine Recipients.

_____ _____ _____

Parent or Guardian Signature | Date | Time

_____ _____

Parent or Guardian Printed Name | Relationship to Patient, if applicable