# TOE RIVER HEALTH DISTRICT COVID-19 CONSENT FORM

**Please complete this form and return with a copy of your Medicare, Medicaid, or Insurance Card.**

**PLEASE PRINT:** **Date of Birth** _____ **Age**_____

**Name** _____ _____

**Last** **First** **Middle**

**Maiden**

**Social Security Number:** _____

**Mailing** **Address**

_____

**City** _____ **State** _____ **Zip Code**

_____

**County of Residence** _____ **Phone #**_____

**1. Have you had close contact (within 6ft for at least 15 minutes) in the last 14 days with someone diagnosed with COVID-19, or has any health department or health care provider been in contact with you and advised quarantine?** ❑ No ❑ Yes

**2. Have you had any of the following symptoms?** ❑ No ❑ Yes

(Fever, chills, shortness of breath or difficulty breathing, new cough, new loss of taste or smell, congestion/runny nose, headache, diarrhea, nausea/vomiting)

**3. In the last two weeks have you had any immunizations?** ❑ No ❑ Yes

**4. Do you have a bleeding disorder?** ❑ No ❑ Yes

**5. Have you recently or are you currently taking anticoagulants (blood thinners)?** ❑ No ❑ Yes

**6. If you answered yes to the questions 4 or 5, have you spoken with your primary care provider about receiving the COVID-19 vaccine?** ❑ No ❑ Yes

**7. Have you had any facial fillers (Botox, etc.)?** ❑ No ❑ Yes

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**Immunization Administered:**

❑ COVID-19 Vaccine dose 1
❑ COVID-19 Vaccine dose 2

**Date of second COVID-19 vaccine dose to be administered** **Date**_____

❑ COVID-19 Vaccine verification card provided to patient
❑ Patient informed of V-Safe app
❑ COVID-19 VIS given

I authorize payment of the above named benefits to Toe River Health District for services received. I acknowledge that a copy of the Toe River Health District Notice of Privacy Practices was made available to me.

**Patient's or Authorized Person's Signature** _____ **Date**

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FOR OFFICE USE ONLY:

| TRHD USE ONLY | | | | | | | |
|---|---|---|---|---|---|---|---|
| | COVID-19 | IMM DATE | DOSAGE ❑ 0.50 ml | ROUTE IM | SITE ❑ LD ❑ RD | MFGR Moderna | LOT # |
| | Nurse's Signature | | | | | Expiration Date: | |
| | | | | | | Data Entry Date/Initials_____ | |

| E O N L Y | Data Entry<br>Date/Initials_____ |
|---|---|

**Copy of insurance card:** ❑ Yes ❑ No ❑ **Uninsured**

**NCIR:** _____ **CureMD:** _____

Toe River Health District services and employment opportunities are offered to all people regardless of race, color, national origin, sex, religion, age, or disability.

Disposition: As POHR Manual destroy form in office after three years

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