Shaw Family Medical Primary/School-Based Clinic

FLU/COVID-19 VACCINATIONS CONSENT FORM

TO BE COMPLETED BY ADULT PATIENT/PARENT OR LEGAL GUARDIAN (Please Print)

Patient Name:		MALE:		FEMALE:	
DOB:		SSN:			
Address:		City/State/Zip:			
Home Phone:		Work Phone:			
Cell Phone:		Consent to text regarding appointments: YES		NO	
School:		Grade:			
Emergency Contact Name and Phone Numbers					
1.		**2.**			
Preferred Pharmacy:					
Parent/Guardian's Name:					
Parent's email address:					
Insurance Information					
Insurance/Medicaid Number:					

Private Insurance Information			
Policy Holder:		Relationship to child:	
Group Number:		Policy Number:	

Additional Information

1. Is the patient allergic to Eggs?
2. Did the patient anwer YES to any of the pre-covid-19 vaccine questions? Please describe:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED. YOU MAY ALSO HAVE ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

We are also required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your medical information. We are required by law to abide by the terms of this notice.

If you have any objections to this form please speak to the HIPPA Compliance officer for SHAW FAMILY MEDICAL, (the providers). A copy of the privacy policy can be found on each provider's website.

***Signature: _____**

SHAW FAMILY MEDICAL

I authorize **SHAW FAMILY MEDICAL** to perform the following procedures;

- Influenza vaccination (to be given during the peak influenza season) Circle Yes or No — **YES** **NO**
- Covid-19 Vaccination Circle Yes or No — **YES** **NO**
- Other Vaccination:_____ Circle Yes or No — **YES** **NO**
- Perform procedure(s) performed at community health event if applicable (please place an X on any services that are declined: — **YES** **NO**

  HIV Screening

  Glucose Screening

  Blood Pressure Screening

  STD Screening

  Free Condom Distribution

*I also authorize **SHAW FAMILY MEDICAL** to file and bill my/my child's Insurance/Medicaid for Medical services rendered.*

***Signature of Patient/Parent/Legal Guardian: _____ Date: _____**

***Printed Name of Patient/Parent/Legal Guardian: _____ Date: _____**