NAU NORTHERN ARIZONA UNIVERSITY

Campus Health Services

PO Box 6033 928-523-2131
Flagstaff, AZ 86011 928-523-4411 fax
nau.edu/campus-health-services

2021

COVID 19 Consent Form

Last Name	**First Name and MI**		**This dose is:** First Dose ☐ Second Dose ☐
Address	**City**	**State** **Zip**	**Phone #**
NAU ID#	**Email address**	**Date of Birth** _____/_____/_____	**Gender (circle)** Female Male Transgender
Emergency Contact or Guardian:	**Name**	**Relationship**	**Phone #**

Do you have current medical insurance? ☐ Yes ☐ No

Ins. Primary Insurance Name:		Telephone:
Address:	City, State, Zip	
Policyholder's Name:	Date of Birth:	Relationship to patient:
Policyholder's Gender: ☐ M ☐ F	Policyholder's Employer:	
Policy Number:	Group Number:	
If you do *not* have insurance fill in this section: **State ID/Driver's License REQUIRED**		
Driver's License Number:	Or, State ID Number and state issued:	

I have read or received the Covid-19 vaccine Fact Sheet and had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risk of the COVID-19 vaccine and request to receive the vaccine today. I agree to have Northern Arizona University Campus Health Services release my information about this vaccination to the Arizona State Immunization Information System (ASIIS) and other health care providers upon request. When insurance is billed, I hereby authorize NAU CHS to furnish information to insurance carriers concerning my visit, and I assign payments for medical services rendered to NAU CHS.

Patient/Guardian Signature_____ **Date** _____

HIPAA NOTICE & ACKNOWLEDGMENT: Northern Arizona University Campus Health Services (NAU CHS) Notice of Privacy Practices provides information about how Protected Health Information may be used and disclosed. The Notice of Privacy Practices contains a Patient Rights section describing your rights under the law. This practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- Personal Health Information may be disclosed/used for health operations, treatment, payment, or what is required by law.
- NAU CHS has a Notice of Privacy Practices. You have the right to review it before signing this acknowledgement. NAU CHS reserves the right to change the Notice of Privacy Practices. The patient may obtain a revised copy by contacting the NAU CHS.
- The patient has the right to restrict the use of their information, but NAU CHS does not have to agree to the restrictions.
- NAU CHS is not required by law to restrict or withdraw any previous information that has been collected; however, NAU CHS shall honor the request for any future information that may be collected.
- The patient may revoke any consent in writing at any time and all future disclosures will then cease. Such revocation shall not affect any disclosure already made.

By signing below, I acknowledge understanding to the statements above and that I have been offered a copy of the Notice of Privacy Practices.

Patient/Guardian Signature_____ **Date** _____

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Patient Name _____ NAU ID#_____ DOB _____

MEDICAL HISTORY	YES	NO	Don't Know
Are you currently ill and/or experiencing COVID-19 like symptoms such as cough, fever, chills or shortness of breath, or are you currently under quarantine for direct exposure to someone who tested positive for COVID-19?	❑	❑	❑
Do you have severe allergies (i.e. anaphylaxis) to **medications, food, a vaccine component, or latex**? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital? If yes, you will be asked to stay for 30 minutes after vaccination.	❑	❑	❑
Have you ever had a severe allergic reaction (i.e. anaphylaxis) after receiving **a vaccine or injectable medication**? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital? If yes, this is a precaution, you will be counselled and you will be asked to stay for 30 minutes after vaccination.	❑	❑	❑
Do you have any medical condition that has compromised your immune system? If yes, be aware there are no studies on the safety or effectiveness of this vaccine in this population.	❑	❑	❑
Do you have a bleeding disorder or are you currently taking a blood thinner medication? If yes, you will need to hold firm pressure to the vaccination site for 2 minutes after vaccination.	❑	❑	❑
Have you received any vaccine in the last 14 days? If yes, please reschedule appt for after 14 days. We also recommend you wait a minimum of 14 days after this vaccination before getting any other vaccines.	❑	❑	❑
Are you pregnant or breastfeeding? If yes, be aware there are no studies on the safety or effectiveness of this vaccine in this population, consider talking with your OB/GYNE/PCP first.	❑	❑	❑
Have you ever had a positive test for COVID-19 or has a provider ever told you that you had COVID-19? If yes, we recommend you wait 30 days after your positive test before getting vaccinated.	❑	❑	❑
Have you received passive antibody therapy as treatment for COVID-19? If yes, vaccination should be deferred for 90 days after antibody therapy.	❑	❑	❑

---------- **FOR STAFF USE ONLY**----------

VACCINE	MGF	LOT #	Expiration date	SITE	ROUTE	DOSE
Moderna COVID-19 Vaccine	Moderna			RD LD	IM	0.5 mL

Notes: _____

Vaccinator Signature_____ Date administered, and Fact Sheet given _____/_____/_____

Vaccination time: _____ End of Observation time: _____

Covid 19 Consent Form 2021 Discharge Observers Signature _____