

SICK OF QUARANTINE? GET A VACCINE!

Niles High School, 1441 Eagle St.
Niles, MI 49120



Wednesday, June 9

3 to 6 p.m.

Parents and family welcome!

BCHD will be offering Pfizer for those 12+ and the J&J vaccine for those 18+. Parent/guardian consent required for those under 18.

Walk-ins welcome! Prefer an appointment?

Make an appointment online at
bchdmi.org/covid19



BERRIEN COUNTY
HEALTH DEPARTMENT



**BERRIEN COUNTY
HEALTH DEPARTMENT**
better health. stronger communities.

COVID-19 VACCINATION CONSENT & CHARGE SLIP

TAX ID# 38-6000191

TODAY'S DATE: ____/____/____ D.O.B.: ____/____/____ AGE: ____ SEX: ☐ Male ☐ Female ☐ Intersex

LEGAL NAME: (Last) _____ (First) _____ (Middle) _____

Maiden/Alias Name: _____ Guardian Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alternate Phone: _____ County: _____

RACE (CHECK ONE): ☐ Black or African American ☐ White ☐ Multiracial ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other _____

ETHNICITY (CHECK ONE): ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown

Screening Questions: If a question is not clear, leave it blank and the nurse will explain it (Client refers to the person receiving the vaccination).

1	Are you feeling sick today?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	Have you previously had a COVID-19 Vaccination? If yes, which vaccine did you receive? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (J&J) <input type="checkbox"/> Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	Have you ever had a serious allergic reaction (e.g. anaphylaxis) to something?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4	Was the severe allergic reaction after receiving a vaccine? If yes: what vaccination:	<input type="checkbox"/> YES <input type="checkbox"/> NO
5	Do you have a bleeding disorder or are you taking a blood thinner?	<input type="checkbox"/> YES <input type="checkbox"/> NO
6	Have you received passive antibody therapy as treatment for COVID-19?	<input type="checkbox"/> YES <input type="checkbox"/> NO
7	Have you received another vaccine in the last 14 days?	<input type="checkbox"/> YES <input type="checkbox"/> NO
8	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	<input type="checkbox"/> YES <input type="checkbox"/> NO
9	Are you pregnant or breastfeeding?	<input type="checkbox"/> YES <input type="checkbox"/> NO
10	If yes to question 9, have you discussed the COVID-19 vaccination with your medical provider?	<input type="checkbox"/> YES <input type="checkbox"/> NO

My signature below proves:

- I have read or had explained to me the Vaccine's Information Statement (Emergency Use Authorization Vaccine Factsheet) and understand the risks and benefit.
- I consent to the administration of the vaccine's to me or to the person for whom I am authorized to make this request.
- I verify that all of the above information I supplied is correct to the best of my knowledge and have received the HIPAA privacy notice.
- I understand that this administration will be recorded to MCIR and may bill my insurance if applicable.

Client/Guardian Signature: _____ Date: _____

If parent/guardian, my signature above consents to the vaccination of my child by the Berrien County Health Department.

Parent/Guardian Name (Printed): _____

Emergency Contact: _____ Phone Number: _____

DO NOT WRITE BELOW THIS LINE

Vaccine	Date Vaccine & FS Given	EUA Public. Date	Vaccine Lot Number	Site Given	Vaccine Dose	Signature of Vaccine Administrator	Eligibility
207 COVID - MODERNA		12/18/20					FP
208 COVID - PFIZER		12/15/20					FP
209 COVID - J&J JANSSEN		2/27/21					FP

Initials: _____