Franciscan Healthcare
Your health is our passion.

COVID-19 Vaccination Registration Form

BRING A COPY OF YOUR CURRENT INSURANCE CARD

INSURANCE CARD

❑ Photo

❑ Copy

PATIENT *(use legal name)*

Last Name _____ First Name _____

Date of Birth _____ Age _____ Sex _____ Social Security # _____

Marital Status *(circle)* S M D W

Spouse's Name _____ Spouse's Date of Birth _____

Race _____ Language: ❑ English ❑ Spanish ❑ Other _____

Address *(Physical, P.O. Box)* _____

City, State & Zip Code _____

Home Phone _____ Cell Phone _____

Email Address _____

PATIENT EMPLOYMENT *(circle)* Full-time Part-time Self-employed

Employer/Business Name _____

Address *(Physical, P.O. Box)* _____

City, State & Zip Code _____

Main Phone _____ Contact Name *(if WC)* _____

GUARANTOR *(use legal name)* Guarantor Relationship to Patient _____

Last Name _____ First Name _____

Date of Birth _____ Sex _____ Social Security # _____

Address *(Physical, P.O. Box)* _____

City, State & Zip Code _____

Home Phone _____ Cell Phone _____

INSURER'S EMPLOYMENT INFO *(circle)* Full-time Part-time Self-employed

Policyholder _____

Employer/Business Name _____

Address *(Physical, P.O. Box)* _____

City, State & Zip Code _____

Main Phone _____

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COVID-19 Vaccination Assessment & Consent

Patient's Name _____ Date of Birth _____

Doctor _____

Have you received a COVID-19 vaccination in the past 30 days? ❑ Yes ❑ No

Have you had a positive COVID-19 test in the past two months? ❑ Yes ❑ No

(If Yes to either of the above questions, vaccination is not indicated.
If No, continue assessment for contraindications.)

Have you ever had a severe (anaphylactic) reaction to a COVID shot? ❑ Yes ❑ No

Do you currently have an illness with fever? ❑ Yes ❑ No

Consent for COVID-19 Injection:

The information on the COVID-19 vaccine statement is not available from the CDC at this time. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of the vaccine and asked that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. Franciscan Healthcare will bill my insurance carrier. I authorize direct payment of benefits to Franciscan Healthcare. I will be responsible for the entire unreimbursed balance of the claim to the extent permitted by law.

Signature of Patient/Parent/Guardian _____ Date _____

FOR NURSE USE ONLY:

COVID-19 Administered

SARS COVID-19 Spikevax Vaccine
Site: RD/LD
RVL/LVL

Administered By _____

Date Given _____

Manufacturer: Moderna

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