WEST CENTRAL DISTRICT HEALTH DEPARTMENT
Lincoln, Logan, McPherson, Thomas, Hooker, & Arthur Counties

Is the patient insured? If yes, please provide a front and back copy of all insurance cards. The patient will NOT be responsible for any charges that insurance does not cover.
YES NO

Appt Date/Time: _____
TIME IN: _____ **STAFF USE ONLY**
TIME OUT: _____
Event Location: _____
Education Provided YES □ NO □
WCDHD educational waiting room T.V. monitor and/or educational packets include

COVID-19 PATIENT ENCOUNTER FORM

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	MEDICAL PROVIDER
RACE	SOCIAL SECURITY #		MOTHER'S MAIDEN NAME		EMAIL
ADDRESS	CITY	STATE	ZIP	COUNTY	TELEPHONE #

Have you had a positive COVID-19 test in the past 90 days? □ Yes □ No **Were you administered monoclonal antibodies in the past 90 days?** □Yes □ No

Are you currently experiencing any of these COVID-19 Symptoms: Fever, Shortness of Breath, Dry Cough, Runny Nose, Sore Throat? □Yes □No

Have you had any vaccine within the past 14 days? □ Yes □ No

Any health problems? (If so, please describe) _____

Diagnosed with asthma □ Yes □ No **Taking a steroid and/or antibiotic/blood transfusion?** □ Yes □ No

Allergic to antacids, buffered aspirin, antiperspirants, gelatin, formaldehyde, thimerosal, or any components of the COVID-19 vaccine?: □ Yes □ No

Other allergies? _____

Current Medications: _____

Any previous reactions to vaccines? □Yes □No **Are you**: □ Pregnant □ Breastfeeding

Have you ever been incarcerated? □ Yes □ No **Any travel outside of the U.S in the past 30 days?** □Yes □ No

How did you hear about our services here at WCDHD? (PLEASE CIRCLE ALL THAT APPLY)
Radio TV Billboard Provider Friend/Family Postcard Facebook Other, please specify_____

Please check which of the following best describes your gender:
□ Male □ Female □ Transgender male/female to male □ Transgender female/male to female □ Choose not to disclose □ Other, please specify_____

Please check which of the following best describes your sexual identity:
□ Straight/heterosexual □ Bisexual □ Lesbian, gay or homosexual □ Don't know □ Other, please specify_____

Please check which of the following best describes your current housing:
□ Homeowner/renting □ Homeless shelter □ Transitional housing □ Living on the streets □ Public housing
□ "Doubling up" with family or friends □ Choose not to disclose □ Other, please specify _____

RESPONSIBLE PARTY INFORMATION, (if different than above)

LAST NAME	FIRST NAME	MI	BIRTHDATE	SS#
ADDRESS		STATE	ZIP	TELEPHONE#

CELLULAR PHONE, TEXT, PHOTO, AND EMAIL CONTACT POLICY: By providing WCDHD with an email address or telephone number for a cellular phone or other wireless device, you are expressly consenting to receiving communications - including but not limited to prerecorded or artificial voice message calls, text messages, emails and calls made by an automatic telephone dialing system - from us and our affiliates and agents at that number. This express consent applies to each such email and telephone number that you provide to us now or in the future and permits such calls, texts, and emails regardless of their purpose. Calls and messages may incur access fees from your cellular provider. From time to time WCDHD takes photos or video of our programs to use in our marketing materials both in print and on the web. By signing this form, you're giving consent to have your photo used for these purposes. If you do not agree to have your photo used, please call WCDHD and we will make arrangements to exclude your photo from use.

HIPAA: By signing this form, I understand the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly; obtain payment from third-party payers; conduct normal healthcare operations such as quality assessments and physician certifications and that my protected health information may be entered into state or national registries, access to which is restricted to persons who have signed agreements to keep all patient registry information confidential. I have been informed by you and your Notice of Privacy Practices containing a more complete description the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

COVID-19 Vaccine Fact Sheet for Recipients and Caregivers. Emergency Use Authorization (EUA) of the Pfizer-BioNTech COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19) in Individuals 16 years of age and older: View Pfizer COVID-19 Vaccine Fact Sheet for Recipients and Caregivers (EUA)

Fact Sheet for Recipients and Caregivers. Emergency Use Authorization (EUA) of the Moderna COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19) in Individuals 18 years of age and older: View Moderna COVID-19 Vaccine Fact Sheet for Recipients and Caregivers (EUA)

By signing below, I acknowledge: I am confirming that I have received and read the COVID-19 Vaccine Fact Sheets (EUA) linked above (You will also receive a copy of each fact sheet to the valid email address you provided in this survey). The above information is true to the best of my knowledge. I understand the benefits and risks of vaccination and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination.

PATIENT/GUARDIAN SIGNATURE DATE

STAFF USE ONLY

Notes:

Original: 9/1/2013 Revised: 7/19/2016; 7/21/16, 5/16/18; 9/23/18, 03/05/2019, 4/8/19; 11/15/19; 12/17/2019
Location: Groups/Health Services/CHECK IN FORMS