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Updated August 2024

- ☐ Office Visit
- ☐ Home Visit
- ☐ Vaccine Event Location:
- ☐ Fluzone
- ☐ Fluzone HIGH DOSE
- ☐ Other: (Please list)
- ☐ COVID

healthymothers healthybabies
COALITION OF HAWAII

Please answer the following questions to help us safely administer your vaccine(s). Healthy Mothers Healthy Babies Coalition of Hawaii is a local non-profit that needs to report on specific demographic questions to continue serving our community. Vaccines are offered free of charge.

Demographic & Insurance Information

First Name	Last Name	Middle Initial	Phone
Mailing Address	**City**	**State**	**Zip Code**
Email Address	**Birthdate**	**Age**	**Estimated Household Income**

Race (check all that apply)

- ☐ Native Hawaiian
- ☐ Micronesian
- ☐ Black or African American
- ☐ White (non-hispanic)
- ☐ Marshallese
- ☐ Chuukese
- ☐ Filipino
- ☐ Chinese
- ☐ Japanese
- ☐ Korean
- ☐ Hispanic or Latino
- ☐ Alaska Native or American Indian
- ☐ Other:

What do you identify as?

- ☐ Female
- ☐ Male
- ☐ Mahu
- ☐ Non-binary
- ☐ Prefer not to answer
- ☐ Don't know
- ☐ Other:

Health Insurance

Subscriber ID #

Main Subscriber Name

Main Subscriber Birthdate

Marital Status

- ☐ Single
- ☐ Separated
- ☐ Married
- ☐ In a Relationship
- ☐ Divorced
- ☐ Widowed

Highest Level of Education

- ☐ Less than High School
- ☐ Some College / 2yr Degree
- ☐ Some High School
- ☐ 4yr / Bachelor's Degree
- ☐ High School Graduate/GED Certificate
- ☐ Graduate Degree
- ☐ Trade School

Receiving Public Assistance?

- ☐ WIC
- ☐ SNAP
- ☐ TANF

Currently employed?

- ☐ Yes
- ☐ No

# of Adults in Household:

# of Children in Household (Please list ages)

Pronoun(s)

- ☐ She/Her
- ☐ He/Him
- ☐ They/Them
- ☐ She/They
- ☐ He/They
- ☐ Other:

Emergency Contact: (First Name, Last Name, Phone #, Relationship)

Patient's Health Information

For patient's 6mos - 4y ONLY: Indicate COVID Vaccine Previously Received

	Dose #1 Date	Dose #2 Date	Dose #3 Date
☐ Pfizer - BioNTech ☐ Moderna			

Please Answer All Questions	**Yes**	**No**	**Don't Know**
1. Do you have any serious reactions from a vaccine, any component of this or other vaccines, or to any injectable medication (intramuscular, intravenous, or subcutaneous?)			
2. Do you have a history of severe allergic reaction (e.g., anaphylaxis) to any medications, foods, pets, insects, venom, environmental triggers, or latex?			
3. Have you had a severe allergic reaction/anaphylaxis to polyethylene glycol or polysorbate?			
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Have you received another vaccine in the last 14 days?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? **Date of positive test:**			
7. Have you been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection?			
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?			
9. Do you have a bleeding disorder or are you taking a blood thinner?			
10. Do you have dermal fillers?			
11. Do you have a history of heparin-induced thrombocytopenia (HIT)?			
12. Are you pregnant or breastfeeding?			
13. Do you have a seizure, brain or nerve problem (such as Guillain-Barre syndrome)?			
14. Do you currently have a cold, fever, or active illness?			

First Name	Last Name	Date of Birth

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The vaccine may not protect everyone from COVID-19 disease or Influenza. Some people may experience side effects after getting the vaccine. Side effects that have been reported include injection site pain, tiredness, headache, muscle pain, chills, joint pain, fever, injection site swelling, injection site redness, nausea, feeling unwell, and swollen lymph nodes. There is a remote chance that the vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the vaccine. For this reason, a vaccination provider may ask the person receiving the vaccine to stay at the place where they received their vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include difficulty breathing, swelling of the face and throat, a fast heartbeat, and/or a bad rash all over the body.

Scan here for Vaccine Fact Sheets & Resources

If you have any additional questions after reviewing the above information, talk to your doctor or healthcare provider before getting the vaccine.

Patient Consent & Waiver

I hereby give my consent to the health care provider of Healthy Mothers Healthy Babies Coalition of Hawaii (HMHB), its affiliates and subsidiaries, to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the vaccine(s) being administered and have received, read and/or had explained to me the CDC's Vaccine Information Statement (VIS) or the FDA's Emergency Use Authorization (EUA) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. I understand that the information contained on this form may be shared with the Stated Health Division (SHD) and/or state immunization registries and will remain confidential and will not be released except as permitted or required by law. If eligible, I authorize HMHB to submit a claim for reimbursement on my behalf to Medicare or any other contracted third party payor. If the claim is denied, I understand that I will be responsible for payment. I understand if my claim to the HRSA Uninsured Fund is not reimbursed because it is determined that I have third-party insurance, I authorize HMHB to utilize my protected health information and other identifiers to try to identify and bill my insurance. Furthermore, I agree to remain near the vaccination location for approximately 15-30 minutes after administration for observation by the administering Healthcare Provider. I have had the opportunity to read and/or have received a copy of HMHB's Notice of Privacy Practices to my satisfaction prior to consent. I acknowledge that I am responsible for communicating the information provided to me about my vaccination to my primary care provider. I authorize the release of any medical or other information necessary to process a claim. If applicable, I request payment of government benefits to either myself or to the party who accepts assignment above. I authorize payment of medical benefits to the undersigned physician, supplier or pharmacy provider for the services provided above.

If I am not the person named above, I hereby affirm that I am over 18 years of age and can legally consent for the person named above to get the vaccine(s).

Signature of Patient / Guardian	**Relationship (SELF if yourself)**
Print name of Guardian	**Date**

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Dose _____ ml IM	**Site**	**Vaccine(s) Received:**	☐ **Pfizer**	☐ **Fluzone**	**Lot #**	**Exp**	
			☐ **Moderna**	☐ **Other:**			
Vaccine Information & Fact Sheets Explained?	☐ **Yes** ☐ **No**	**Vaccinator Name & Title (Printed)**		**Vaccinator Signature**		**Date**	
Apricot Intake and Program Tracking Completed (Staff Initial)		**HIR Completed (Staff Initial)**		**Billing Completed (Staff Initial)**			

Additional Notes: