PROJECT VISION HAWAI`I

Date: ______________

COVID-19 Vaccine Screening Form

Location: ____________

RECIPIENT'S NAME Last, First, M.I., Suffix		DATE OF BIRTH ___/___/_____ Month / Day / Year	GENDER M F X
RECIPIENT OR AUTHORIZED POA EMAIL		PHONE NUMBER	
RECIPIENT ADDRESS		CITY	Zip Code
Insurance Member ID # or SSN	Medical Insurance Company	Subscriber Name and DOB (if other than self)	

RACE/ETHNICITY (Circle all the apply)

Native Hawaiian, Micronesian, Marshallese, Chamorro, Samoan, Tongan, Other Pacific Islander, Filipino, Chinese, Japanese, Vietnamese, Korean, Other Asian, Black/African American, Native American, Hispanic/Latino, White, Other: _________

Where did you sleep last night? (Circle one)
Friend's home or couch surfing, My Apartment or House, Outside, Park / encampment, Shelter, Street, Vehicle

Homeless status? Y N Staff or Client

Observation:

Question	Yes	No
1. Have you been previously vaccinated with any COVID-19 Vaccine? If vaccine product Pfizer COVID-19 Vaccine **AND** at least 21 days since first dose received, proceed to next question. If Moderna COVID -19 Vaccine AND at least 28 days since first dose received, proceed to next question. Otherwise, COVID-19 vaccine may not be administered. *Must provide written documentation of previous vaccination with product type.*	Yes If Yes, Product Name: __________ Dates Received: __________	No
2. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to a vaccine, any component of this or other vaccines, or to any injectable medication (intramuscular, intravenous, or subcutaneous)?	Yes	No
3. Do you have a history of a severe allergic reaction (e.g., anaphylaxis) to any medications, foods, pets, insects, venom, environmental triggers, or latex?	Yes	No
4. Are you Immunocompromised?	**I Yes**	**I No**

CDC recommends that moderately to severely immunocompromised people receive an additional dose. This includes those:

- Receiving active cancer treatment for tumors or cancers of the blood
- Received an organ transplant and are taking medicine to suppress the immune system
- Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
- Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- Advanced or untreated HIV infection
- Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response

If you are unsure, talk to your healthcare provider about any medical conditions, and the appropriateness of an additional dose.

Acknowledgment & Consent

I, the undersigned, agree that Project Vision Hawai`i (PVH) may provide me with the medical services described above. I permit PVH to arrange for the clinical analysis, reporting and interpretation of these medical services. *I have been given a copy or directed to the Fact Sheet for Recipients and Caregivers for this COVID-19 vaccine and have read it. I have had the chance to ask questions and I am satisfied with the answers and explanations given. I understand that the CDC recommends full series of vaccinations*

and boosters within the appropriate timeframes, explained in detail here: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html. I understand that the COVID-19 vaccine has been FDA (Food and Drug Administration) approved for individuals 12 years and older for Pfizer, and 18 years and older for Moderna and Janssen COVID-19 vaccines. I understand that the boosters have been EUA approved for eligible individuals who received their second dose more than 5 months prior for Pfizer (monovalent), 2 month prior for Pfizer (bivalent), 2 months prior for Moderna (bivalent), and 2 months prior for Janssen. I understand that the COVID-19 vaccine for youth has not yet been approved by the FDA, and is being given under an FDA issued EUA. I understand the benefits and risks of this vaccine and ask that the vaccine be given to me, or the person for whom I am authorized to make this request. I understand that not all versions of these COVID-19 vaccines are FDA-approved vaccine but is being given under an FDA-issued Emergency Use Authorization, the State of Hawaii, its departments, agencies and employees ("the State"), as well as Project Vision Hawai'i (the covid provider administering my vaccine) are immune from civil liability under federal and state law for all claims for loss related to any known or unknown side effects and/or injuries, including but not limited to death, that I, or the person for whom I am authorized to make this request, may experience from this vaccine. This immunity means that if I file a lawsuit against the State, the court must dismiss any such lawsuit, and the only exception to this immunity is for claims of willful misconduct. In addition, I have received information regarding the Vaccine Administration Management System (VAMS) or the Hawaii Immunization Registry (HIR). See attached.

I acknowledge the above and request the vaccine be administered to me, or to the named recipient.

Recipient Name (Print)	**Recipient Signature**	**Date**
Parent/Legal Guardian/POA Name (Print)	**Signature of Parent/Legal Guardian/POA**	**Date**

-----------------------------**Vaccine documentation** - *For Clinic Use Only* -------------------------------------

Medical Screener Authorization ***Clear to Vaccinate? Yes No***

WEIGHT (for infants only): ___________ Dose liquid epi required in case of emergency: _________

Form Reviewed by ______________________________ ______________

(Print Provider Name) *(Signature)*

Vaccine Not Administered (Reason): ____

COVID-19 Vaccine (circle one)	**Dose #** (Circle all that apply)	**Date & Time Dose Administered**	**Dose Amount** (circle one)
MONOVALENT Moderna MONOVALENT Pfizer BIVALENT Moderna BIVALENT Pfizer J&J	Infant / PEDS / 12+ (circle one) #1 #2 #3 Booster (circle one)	/ / : am/pm	0.2 mL 0.3 mL 0.25 mL 0.5 mL

Route	**Vaccine Manufacturer**	**Lot Number**	**Name and Initials of Vaccine Administrator** *(if different from above)*
IM RA LA	Pfizer Moderna Janssen		

Observations:

To be completed by PVH Staff
Medical Record #: ______________
Name: ______________
Date of Birth: ______________

Consent to Payment

I hereby assign to Project Vision Hawai'i all rights privileges and remedies to payment for health care services provide. All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments before services are rendered.

1. **Financial Agreement**
   - I understand payment for costs not covered by the patient's insurance or other third-party payor(s) is the responsibility of the patient or the patient's legal representative.
     - This may include co-pays, deductibles, or costs for evaluations/treatment that are not included as an insurance benefit.
   - I understand if bills are not paid on time, the account may be sent to collections.
     - If this happens, I understand the patient or the patient's legal representative will have to pay for the cost of the collection and/or reasonable fees from the collection.
   - If I have a credit balance or overpayment, it will be applied to any outstanding or unpaid balances on my account(s), before I receive a refund.
   - I understand that once my deductible is met, Medicare pays for 80% of the allowable charges and I am responsible for all remaining balances not covered by Medicare.

2. **Assignment of Insurance Benefits**
   - I hereby assign all benefits, to include major medical benefits to which I am entitled to Project Vision Hawai'i for the care I receive.
   - I hereby authorize and direct my insurance carrier(s), including Medicaid and/or Medicare, private insurance, auto or any other health/medical plan, to issue payment check(s) directly to PROJECT VISION HAWAII, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any.
   - I understand I am responsible for any amount nor covered by insurance.
   - I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

3. **Authorization to Release Information**

   I hereby authorize PROJECT VISION HAWAII to

   1. Release any information necessary to insurance carriers regarding my treatments and conditions;
   2. Process insurance claims generated during the examination, screening, and/or treatment; and
   3. Allow a photocopy of my signature to be used to process insurance claims for the period lifetime.

   This order will remain in effect until revoked by me in writing.

   I have requested medical services from PROJECT VISION HAWAII on behalf of myself and/or my dependents, and understand by making this request, I become fully financially responsible for any and all charges not covered by insurance if any incurred in the course of this treatment.

   I further understand that fees are due and payable on the date that the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy or digital copy of this assignment is to be considered as valid as the original.

I have read and understood this form and I accept and agree to follow the conditions contained therein.

Signature: ______________________________ Date: ______________

If other* than patient, PRINT your name: ______________________________

Relationship to patient (please circle): Patient/Self, Parent, Guardian, Legal Representative, Other: ______________

**If patient is a minor, unable to sign, and/or is incompetent to give consent, relationship of person authorized to give consent (unless otherwise specified by law) must be indicated.*

PVH WITNESS: ______________________________ Date: ______________

PROJECT VISION HAWAIʻI
Hele for Health

To be completed by PVH Staff
Medical Record #: ____________
Name: ____________
Date of Birth: ____________

Consent to Treatment

1. **Consent to Treatment**
   - I agree to receive treatment from Project Vision Hawaiʻi mobile facilities as provided or ordered by doctors, nurses, assistants, and other staff employed or contracted by Project Vision Hawaiʻi.
   - I understand my care may include physical exams, comprehensive visual exams, evaluations, lab tests, procedures, medicines, and other treatment or monitoring, which in my provider's judgement may be helpful to care for my health, facilitate preventative care, or address other medical concerns.
2. **Non-Discrimination Policy**
   I understand Project Vision Hawaiʻi will treat patients regardless of race, color, national origin, religion, sex, sexual orientation, marital status, veteran's status, age, disability, or housing status.
3. **Consent Effective**
   I understand this consent remains in effect until terminated in writing by me or until legal circumstances change such that a new consent is required.
4. **Changes to Form**
   I understand if I refuse to sign this form or make any changes to this form prior to services being provided it may keep me from getting care and services, except for urgent care/treatment.

I have read and understood this form and I accept and agree to follow the conditions contained therein.

Signature: ______________________________ Date: ____________

PRINT name if other* than patient: ______________________________

Relationship to patient (please circle): Patient/Self, Parent, Guardian, Legal Representative, Other: ____________

**If patient is a minor, unable to sign, and/or is incompetent to give consent, relationship of person authorized to give consent (unless otherwise specified by law) must be indicated.*

To be completed by PVH Staff

Medical Record #: ____________________

Name: ____________________

Date of Birth: ____________________

Privacy Practice Acknowledgement

The Health Insurance Portability and Accountability Act (HIPAA) requires us to give you a notice of our privacy practices and to acknowledge your receipt of the notice.

The Notice of Privacy Practices explains how your health information may be used and or disclosed by us, it explains your rights with regards to your protected health information, as well as our legal responsibilities. You can view the Privacy Practices in one of three manners: we can email you a copy, you can view on our website (www.projectvisionhawaii.org/medical-documentation), or you may request a paper copy.

I have been provided with a copy of the Notice of Privacy Practices in electronic or paper format.

Signature: ____________________ Date: ____________________

PRINT name if other* than patient: ____________________

Relationship to patient (please circle): Patient/Self, Parent, Guardian, Legal Representative, Other: ____________________

**If patient is a minor, unable to sign, and/or is incompetent to give consent, relationship of person authorized to give consent (unless otherwise specified by law) must be indicated.*

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify):

PVH WITNESS: ____________________ Date: ____________________

Consent and Authorization to Release Medical Record; Release of Liability

I. MEDICAL RELEASE Authorization
I hereby consent to and authorize the aforementioned test and/or vaccine by Project Vision Hawai'i and its agents and volunteers. I permit the Provider to prepare and administer my vaccine, or to analyze and interpret my Test, the disclosure of my Test results, in any manner permitted by federal or state privacy and security laws, to the following organizations: State of Hawai`i, Department of Health, Disease Outbreak Division, located at 1250 Punchbowl St., Rm 443, Honolulu, HI 96813, and the host of this event

facility: ___________________________________., located at ___________________________________, if applicable. For houseless individuals that are previously registered with HMIS, Partners in Care Manager and Homeless Management Information System (HMIS) Manager, located at 200 N. Vineyard Blvd., Ste 210, Honolulu, HI 96817. This consent and authorization is valid the day this document is signed by me and expires after one (1) year.

II. Notice of Privacy Practices Acknowledgment
I understand under the Health Insurance and Portability and Accountability Act of 1996 (HIPAA), and Health Information Technology for Economic and Clinical Health Act of 2013 (HITECH) Omnibus Rule, I have certain rights to privacy regarding my protected health information. By signing this form, I ac

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers unless directly requested to withhold PHI from health plan and all healthcare services are paid in full by paying out of pocket.
3. Conduct normal healthcare operations such as quality assessments.
4. My consent and authorization will result in the use or disclosure of my protected health information (PHI). Though precautions will be taken to protect the confidentiality of my PHI, I understand the transmission of PHI presents risks and the confidentiality of such information may be compromised by failures of security safeguards or illegal tampering.

By signing this form, I acknowledge I have seen PVH's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand PVH has the right to change its Notice of Privacy Practices from time to time and I may contact the organization at any time to obtain a current copy of the Notice of Privacy Practices.

III. Waivers
In consideration for receiving the opportunity to receive the vaccine for my child, I hereby RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE Project Vision Hawai`i located at 1110 Nu'uanu Avenue., Honolulu, HI 96817 or the State of Hawai'i or the host location organizations, and its officers, servants, agents, employees, direct or indirect owners, or direct or indirect subsidiaries (the "Project Vision Hawai`i Releasees" and/or enter host site name ") from and against any and all SUITS, ACTIONS, LOSSES, DAMAGES, CLAIMS, OR LIABILITY OR ANY CHARACTER, TYPE OR DESCRIPTION, INCLUDING ALL EXPENSES OR LITIGATIONS, COURT COSTS, AND ATTORNEY'S FEES FOR INJURY OR DEATH TO ANY PERSON, OR INJURY TO ANY PROPERTY, RECEIVED OR SUSTAINED BY ANY PERSON OR PERSONS OR PROPERTY, ARISING OUT OF, OR OCCASIONED BY, DIRECTLY OR INDIRECTLY, WHETHER CAUSED BY THE NEGLIGENCE OF THE PROJECT VISION HAWAI`I RELEASEES OR OTHERWISE, ADMINISTERING A VACCINE BY A PROJECT VISION HAWAI`I EMPLOYEE) OR MY PRESENCE ON SELECTED HOST PROPERTY TO OBTAIN A VACCINE. I hereby accept and assume all risks to myself involved in the administration of the vaccine and/or test to me and fully assume all responsibility for injury, damage, or claim of any nature whatsoever that may result from such administration.

I certify that (i) this document has been completely explained to me; (ii) I read this document or someone read it to me; (iii) all of my questions regarding this document have been answered; and (iv) I completely understand this document.

____________________	____________________	____________
Print Name:	Signature	Date

If signed by someone other than the patient or parent of a minor child, please provide documents to show authority to release of patient's protected health information.

Relation to patient: ______________

PVH Witness: ________________

INFORMATION CONTAINED IN THE REGISTRY HAWAII IMMUNIZATION REGISTRY INFORMATION

- Immunization information including but not limited to vaccine type, date of vaccine administration, vaccine administration site and route, lot number, expiration date, patient's history of vaccine preventable diseases, contraindications, precautions, adverse reactions, and/or comments regarding vaccinations.
- Personal information including but not limited to an individual's first, middle, and last name, date of birth, gender, mailing address, phone number, parent/guardian name, parent/guardian relationship to the individual, their contact information, and mother's maiden name.

CONFIDENTIALITY AND PRIVACY INFORMATION

All authorized users and the Department of Health Immunization Branch acknowledge that the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (PL 104-191 and 45 CFR Parts 160 and 164, "Standards for Privacy of Individually Identifiable Health Information") governs the use and disclosure of individually identifiable information by entities subject to the Privacy Rule. Although HIPAA standards for privacy were used as a guide to assist in the development of the Registry Confidentiality and Privacy policies, the Registry and the Department of Health Immunization Branch are not "covered entities" under HIPAA. Providers, health plans and other covered entities who are authorized users must comply with the HIPAA Privacy Rule.

Registry information will be entered by and available to authorized users for authorized purposes only. All authorized users will be required to safeguard the privacy of patient participants by protecting confidential information in the Registry in accordance with the Hawaii Immunization Registry Confidentiality and Privacy Policy, the Hawaii Immunization Registry Security Policy, as well as all applicable State and Federal Laws.

AUTHORIZED USERS Authorized users of the Registry may include individuals and/or entities that require regular access to patient immunization and other individually identifiable health information to provide immunization services to specific patients, maintain a computerized inventory of their public and private stock of vaccines, assess immunization status to determine immunization rates, and/or ensure compliance with mandatory immunization requirements. All authorized users are required to sign a Hawaii Immunization Registry Confidentiality and Security Statement indicating that they have received a copy of the Hawaii Immunization Registry Confidentiality and Privacy Policy and the Hawaii Immunization Registry Security Policy, understand the terms, including penalties for violation of the policies, and agree to comply with the policies. The Department of Health Immunization Branch is responsible for oversight of the Registry and therefore will be designated as an authorized user.

USES OF REGISTRY INFORMATION (AUTHORIZED PURPOSES)

Registry immunization data and other individually identifiable health information shall be utilized by authorized users for the purposes of:

- Consolidating, maintaining, and accessing computerized immunization records;
- Consolidating and maintaining vaccine inventory information;
- Determining the immunization history of individuals and delivering health care treatment accordingly;
- Generating notices for individuals who are due or overdue for immunizations and in the event of a vaccine recall;
- Staying abreast of the complex immunization schedule by utilizing registry-supplied immunization forecasting tools;
- Assessing the immunization rate of their patient population (or subsets thereof);
- Generating official immunization records (e.g. Student's Health Record);
- Ensuring compliance with mandatory immunization requirements;
- Recording the distribution of prophylactic and treatment medications administered or dispensed in preparation for and in response to a potentially catastrophic disease threat;
- Complying with Hawaii Vaccines For Children and other State-provided vaccine programs' vaccine ordering and accountability policies and procedures; and
- Other purposes determined at the discretion of the Department of Health Immunization Branch.

Registry immunization data and other individually identifiable health information shall be utilized by the Department of Health Immunization Branch for the following public health purposes including but not limited to:

- Ensuring compliance with mandatory immunization requirements;
- Performing Quality Improvement/Quality Assessment activities;
- Complying with Hawaii Vaccines For Children and other State-provided vaccine programs' vaccine ordering and accountability policies and procedures;
- Preventing and managing outbreaks of vaccine-preventable diseases and other public health emergencies;
- Producing immunization assessment reports to aid in the development of policies and strategies to improve public health;
- Managing and maintaining the Registry system; and
- Other purposes determined at the discretion of the Department of Health Immunization Branch.

AVAILABILITY OF IMMUNIZATION RECORD INFORMATION An individual's immunization data and other individually identifiable health information in the Registry will be made available to the individual's immunization provider, the Department of Health, and other Registry authorized users for authorized purposes only.

OPT-OUT Individuals may choose not to include their or their child's immunization data in the Registry ("opt-out"). Individuals must opt-out in writing by completing a "Hawaii Immunization Registry Opt-Out Form" which is available from the individual's immunization provider or the Department of Health Immunization Branch. The Registry will retain only core demographic information necessary to identify the individual has chosen to opt-out of the Registry. This information is necessary to enable the Registry to filter and refuse entry of immunization information for the individual. Core demographic data will be for Hawaii Department of Health use only and will be non-displaying to all other Registry authorized users. An individual's decision not to authorize the inclusion of immunization data in the Registry will not affect whether or not they receive immunizations.

REVOCATION An individual may revoke their decision to opt-out of the Hawaii Immunization Registry at any time. Revocations must be made in writing by completing a "Hawaii Immunization Registry Reauthorization Form" obtained from the individual's immunization provider or the Department of Health Immunization Branch.

RIGHT TO INSPECT, COPY, CORRECT OR AMEND PERSONAL AND IMMUNIZATION INFORMATION

Individuals may inspect, copy, correct or amend their or their child's immunization record information via their or their child's immunization provider. For information on how to inspect, copy, correct or amend your or your child's information, please speak with your doctor.

QUESTIONS?

If you have any questions about the Registry, please speak with your doctor or visit our website at: http://health.hawaii.gov/docd/hawaii-immunization-registry

Considerations from the CDC

Anyone 12 years and older is eligible for Vaccine Administration of Pfizer or Moderna COVID-19 Vaccine with other vaccines

- Covid-19 vaccines and other vaccines may now be administered without regards to timing. If multiple vaccines are administered at a single visit, administer each injection in a different injection site.
- Extensive experience with non-covid-19 vaccines has demonstrated that immunogenicity and adverse event profiles are generally similar when vaccines are administered simultaneously as when they are administered alone.

History of a previous or current COVID-19 infection

- You may receive a COVID-19 vaccine if you have had a previous COVID-19 infection.
- If you have a current COVID-19 infection, you should wait until you are better and have completed your isolation time before coming in to get a COVID-19 vaccine.
- There is no recommended minimum time between recovering from a COVID-19 infection and getting a COVID-19 vaccine.
- History of unprotected exposure to a person who tested positive for COVID-19 in the last 14 days
- If you have had an unprotected COVID-19 exposure, you should wait to complete your quarantine before coming in to get a COVID-19 vaccine.
- If you have been treated with a monoclonal antibody or convalescent plasma
- You should wait at least 90 days to get a COVID-19 vaccine after treatment with a monoclonal antibody or convalescent plasma for a COVID-19 infection.

Special populations: If you are immunocompromised, pregnant, or breastfeeding

- A COVID-19 vaccine may be administered to immunocompromised individuals, including people with HIV and those on immunosuppressive medications, but the vaccine has not been fully studied in this population.
- Any of the currently authorized COVID-19 vaccines can be administered to pregnant or lactating people; ACIP does not state a product preference. However, pregnant, lactating, and post-partum people aged <50 years should be aware of the rare risk of TTS after receipt of the Janssen COVID-19 vaccine and the availability of other FDA-authorized COVID-19 vaccines
- In April, the CDC and the FDA issued a pause on administering Janssen due to reports of a very rare and serious blood clotting disorder, a blood clot in the brain called cerebral venous sinus thrombosis (CVST), combined with thrombocytopenia, or low platelets, the cells that help blood clot. The committee found that out of the nearly 8 million Johnson & Johnson vaccine doses administered in the United States, there were only 12 total confirmed cases of this rare combination of CVST and low platelets. Broadening the criteria to include all blood clots (not just in the brain) and low platelets, a condition called thrombosis with thrombocytopenia syndrome (TTS), there were 15 cases. On April 23, CDC and FDA recommended use of Johnson & Johnson's Janssen (J&J/Janssen) COVID-19 Vaccine resume in the United States after a temporary pause. Reports after the use of J&J/Janssen COVID-19 Vaccine suggested an increased risk of the rare adverse event TTS. Most reports of this serious condition, which involves blood clots with low platelets, have been in adult women younger than 50 years old.

If you have any additional questions after reviewing the above information, talk to your doctor or healthcare provider before getting the COVID-19 Vaccine.