Date _________ Apt Time ________

Pf	M	Jn
1	2	3

Patient Name ____
Last *First* *Middle*

Date of Birth ______ / _______ / _______ Sex M F

IN _____________

Ethnicity
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Decline

Race
- ☐ White
- ☐ Native Hawaiian/Pacific Islander
- ☐ Asian
- ☐ Black/African-American
- ☐ American Indian or Alaska Native
- ☐ Other

Mailing Address ____ Phone _________________________

City _____________________________ State _______ Zip ______________ Mobile_________________________

Email ____ ☐ SMS Reminder

Acknowledgement and Consent: Please check the boxes to the right of each item.

1. **Consent to Treat:** I authorize Missoula City-County Health Department to administer treatment as deemed necessary for care of the patient named above. If applicable, I certify that I am the parent or legal guardian of the patient. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment. ☐
2. **Assignment of Benefits:** I authorize payment of medical benefits to Missoula City-County Health Department for services rendered. ☐
3. **Privacy Notice:** I have reviewed a copy of the Notice of Privacy Practices, which provides a description of information uses and disclosures. I may request a copy of the Notice of Privacy Practices for my own records. ☐

I authorize my healthcare provider and local public health agency to collect and enter my or my child's immunization records into the Department of Public Health and Human Services immunization registry (imMTrax), a confidential computer system that contains immunization records. I understand that information in the registry may be released to local health departments, as well as my health care providers to assist in my or my child's medical care and treatment. In addition, information may be released to child-care facilities and schools in which my child is enrolled to comply with state requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department.

ACCEPT imMTrax State Immunization Registry ☐

DECLINE imMTrax State Immunization Registry ☐

Safety Acknowledgement and Waiver

EUA COVID-19 Fact Sheet: I have read or have had explained to me the information contained in the fact sheet about the disease and the vaccine. ☐

Authorization: I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine to be administered today to me or to the person named above for whom I am authorized to make this request. ☐

I understand that I must wait the full 15-30 minutes depending on my risk factors. This is a safety precaution to avoid possible problems associated with fainting or an allergic reaction. ☐

Client (Parent/Guardian) Signature: ____ **Date:** _________________

Guardian or Emergency Contact ____ **Phone** __________________

Office Use Only

Dose 1: ____ **Dose 2:** ____ **Dose 3:** ____

Manufacturer/Lot # ______________________

☐ No contraindications or precautions to vaccinations

Loc: **L**-Deltoid **R**-Deltoid ______________________ **Start time** __________ **Finish Time** __________

Reviewed by/Vaccinator Signature: ____ **Date:** __________________