KAUAI VETERANS MEMORIAL HOSPITAL
4643 Waimea Canyon Dr, Waimea, HI 96796
(808) 338-9431

HAWAI'I HEALTH SYSTEMS CORPORATION
KAUA`I REGION

SAMUEL MAHELONA MEMORIAL HOSPITAL
4800 Kawaihau Rd, Kapa'a, HI 96746
(808) 822-4961

SMMH Third Dose Community COVID Vaccine Intake Consent Form

Recipient Information:

Last Name	First Name	Middle Name	/ / Date of Birth	☐ F ☐ M Gender

Phone Number	Email

Street Address	*City*	*State*	*Zip Code*

Insurance Provider	*Group Number*	*Policy Number*

Ethnicity: ◯ Hispanic or Latino ◯ Non-Hispanic or Non-Latino

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

COVID -19 Screening Questions	**YES**	**NO**	**DON'T KNOW**
1. Have you had a POSITIVE COVID-19 test result / diagnosis in the last 90-days?	◯	◯	◯
If you answered yes to #1: Have you received monoclonal antibodies for COVID-19 in the past 90-days?	◯	◯	◯

Immunization Screening and Attestation Questions

I qualify for the third dose (Pfizer booster):

(Select one)

◯ I had two doses of Pfizer Vaccine at least 6 months ago
◯ I had two doses of Moderna Vaccine at least 6 months ago
◯ I had one dose of Johnson & Johnson (J&J) Vaccine at least two months ago

(Select all that apply below)

☐ Weakened Immune System and at least 28 days since last dose
☐ Age - 65 years or older
☐ Nursing Home, Assisted Living, or Foster Home Resident
☐ Age - 18 to 64 years old with underlying medical conditions (cancer, diabetes, asthma, HIV, heart disease, obesity)
or those that are at risk for COVID-19 exposure and transmission in work setting (healthcare, fire, police, congregate care, education, daycare, food & agriculture, manufacturing, corrections, US Postal Service, public transit, and grocery store workers).

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CONSENT FOR SERVICES: I/my caregiver have been provided with a fact sheet corresponding to the COVID vaccine that I am receiving. I/my caregiver have read the information provided about the vaccine I am to receive. I/my caregiver have had the chance to ask questions that were answered to my satisfaction. I/my caregiver understand the benefits and risks of vaccination and I voluntarily consent to vaccination and assume full responsibility for any reactions that may result. I/my caregiver understand that l should remain in the vaccine administration area for a minimum of 15 minutes after the vaccination to be monitored for any potential adverse reactions. I/my caregiver understand if I experience side effects after leaving that I should do the following as needed: contact my doctor or call 911. I/my caregiver attest that I meet current qualifications for the third dose and request that the vaccine be given to me.

X _____ / / _____

Signature of vaccine recipient or their caregiver indicates acceptance to receive vaccine Date

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To be filled out by the Immunizer: *Patient Temperature:* _____ *Date:* _____

*Vaccination Time:*_____ ❑ *L Arm* ❑ *R Arm* *Lot #* _____ *RN Initials:*_____

If patient's bodily temperature is 100º F or greater, please inform them that they should not receive the vaccine at this time. Instruct them to contact their primary care provider for next steps.

Previous Vaccine Information

Vaccinated at: ❑ SMMH ❑ KVMH ❑ Wilcox ❑ DOH ❑ Other _____

If Vaccinated outside of HHSC Kauai Region, please complete the following:

Vaccine Received: ❑ Pfizer ❑ Moderna ❑ J&J

1st Dose Date _____Lot #_____ 2nd Dose Date _____Lot # _____