Form 10/2021

Missoula City-County Health Department
HEALTH SERVICES
301 W Alder Street| Missoula, MT 59802-4123
PHONE | 406.258.4745
FAX | 406.258.4913

CHECK LIST: 3rd Party Authorization Form

This form may be used if the parent/legal guardian is unable to accompany their child(ren) to Missoula City-County Health Department for Immunization Clinic Services and are authorizing another adult to bring in their child(ren).

Parent/legal guardian must:

- ☐ **Complete the *3rd party authorization forms***
- ☐ **Include a copy of a valid photo ID of the Parent/Legal Guardian completing the forms**
- ☐ **Complete registration form**
- ☐ **Complete pre-vaccination checklist**
- ☐ **Include a copy of your adolescent's insurance card (front and back)**
- ☐ **Send all of the above information with you adolescent to their visit**
- ☐ **Review the Emergency Use Authorization information for the Covid-19 Pfizer vaccine**
- ☐ **The authorized 3rd party must bring a valid ID**

Insurance subscriber's name _____

Subscriber's date of birth ____/____/_____

Subscriber's address _____

If you have questions, please call (406) 258-4636

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3rd Party Authorization Form

Please review the following information and authorization for immunizations or other clinic services when you cannot be present at the time of treatment.

I (we) have the legal right to designate 3rd party authorization to the following individual* to bring my child/dependent to MCCHD to receive services from the Outpatient Clinic:

_____

Last Name First Name MI Date of Birth
(* the authorized 3rd party individual must bring a photo ID)

Please review the following information and authorization for COVID-19 Pfizer vaccination when you cannot be present at the time of COVID-19 vaccination. Sign if you wish to authorize Missoula City-County Health Department (MCCHD) to provide this designated service to your child/dependent.

I (we) have the legal right to preauthorize this facility to deliver the COVID-19 Pfizer Vaccine to my (our) child/dependent for the services provided by MCCHD. I (we) request and authorize MCCHD and its personnel to deliver the following services to my (our) child/dependent listed below. I (we) understand that I (we) will be notified by telephone (at the contact number listed below) in the event of an adverse reaction after receiving services (i.e. fainting). I (we) understand that upon receiving a COVID-19 Pfizer vaccine, my (our) child/dependent must wait at the clinic for 15-30 minutes for observation.

Please select all services requested:

☐ COVID-19 Pfizer Vaccine Dose #1:_____ Dose #2:_____Booster or Dose #3:_____

Client information:

_____ / /
Last name First name MI Date of Birth

Parent/Legal Guardian Information:

_____ / /
Last name First name MI Date of Birth

_____ / /
Last name First name MI Date of Birth

Relationship to client (select one): ☐ Mother ☐Father ☐ Other*:_____

☐ Legal Guardian/Authorized Representative* (*documentation must be provided)Contact information for

Parent/Guardian: phone #: Alternate phone #:

Parental/Legal Guardian Consent for MCCHD Outpatient Immunization Clinic Services
I give permission for my child/dependent to be seen by nursing staff at MCCHD as indicated above. I understand that MCCHD will inform me of any emergency regarding my child/dependent by phoning my contact telephone listed above.

X_____
Signature of Parent/Legal Guardian DATE

Release of Information:

I give permission for MCCHD Outpatient Immunization Clinic to request and/or share my child's/dependent's immunization record as needed for continuity of care with other medical providers, schools, and/or day care.

X _____

Signature of Parent/Legal Guardian DATE

You must attach a copy of your photo ID (driver's license, passport etc). Authorization expires 30 days from the date of signature*. *If signing for two consecutive vaccine doses within 30 days, screening and registration paperwork must be completed for both dates of service on the date of the vaccine.

Date _____ Apt Time _____

Missoula Public Health
City-County Health Department

M Pf Jn

Patient Name _____
Last *First* *Middle Initial*

1 2 3 B K

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. ☐
4. **Declaration of Truth**: All of the information I have provided is accurate and true. ☐

I authorize my healthcare provider and local public health agency to collect and enter immunization records into the Department of Public Health and Human Services "imMTrax" registry, a confidential computer system which contains immunization records. I understand information in the registry may be released to local health departments, as well as health care providers to assist in my or my child's medical care and treatment. In addition, information may be released to my child's child-care facilities and schools 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: ____ **2**: ____ **3**:____ **B**:___

Manufacturer/Lot #

_____

☐ No contraindications or precautions to vaccinations

Loc: **L**-Deltoid **R**-Deltoid

_____

Start time _____ **Finish Time** _____

Reviewed by/Vaccinator Signature: _____ **Date:** _____

Prevaccination Checklist for COVID-19 Vaccination

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product(s) did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	☐	☐	
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)*	☐	☐	☐
4. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	☐	☐	☐
5. Have you ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following:			
○ Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
6. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

7. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ Have a history of Guillain-Barré Syndrome (GBS)

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists