Cherokee Nation Health Services
Registration and Consent for COVID-19 Vaccine and/or Influenza Vaccine

Please fill out completely and print clearly

Name: Last _____ First _____ M.I. _____ Other Names Used: _____

Sex: M F Date of Birth: _____ Marital Status: (Circle One): Single Married Divorced Widowed

Social Security Number: _____Tribe of Membership: _____ Tribal #: _____

Mother's Maiden Name _____Father's Name _____

Home Phone: _____ Alternate Phone: _____

Currently Mailing Address: _____ City: _____ State: _____Zip: _____

If child is not a member of a federally recognized tribe, is child living in home with step parent, foster parent, adoptive parent, or guardian who is a member of a federally recognized tribe? Y or N

Medicaid/SoonerCare #: _____ Medicare #: _____

Name of Insurance Carrier: _____

Address of Insurance Company: _____ Insurance Phone #: _____

Policy # _____ Group #: _____ Effective/Beginning Date of Policy: _____

Policyholder Name: _____ Policyholder Date of Birth: _____/_____/_____

Policyholder's Address: _____ City: _____ State: _____ Zip: _____

Employer Name and Address: _____

Patient Portal Registration: All Patients may have access to their medical records online through the Patient Portal. Patients Age 0-12 require use of parents' email address. Patients Age 13-17 may sign-up for the Patient Portal using minor's own email address. For Age 13-17: Patient Portal Proxy Form must be completed if granting Parent/Guardianship Access.

Patient Portal Preferred Email Address: _____

Consent and Acknowledgement

I understand that the information given by me or collected is necessary for Cherokee Nation Health Services (CNHS) to provide for my health wellbeing. I understand CNHS will seek payment from any medical program that I might be eligible to participate in or from any liable third party and I assign to CNHS all benefits for services rendered by CNHS. I understand that CNHS may verify the information necessary to process the claim.

_____ **I consent to receive the Influenza vaccination** for myself or as the parent/legal guardian of the above patient.

_____ **I consent to receive the COVID-19 vaccination** for myself or as the parent/legal guardian of the above patient and have been provided the Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS). I have had the opportunity to read, discuss the information, and to ask questions regarding COVID-19, the COVID-19 vaccine, and the associated risks and benefits.

I am directing CNHS to disclose my/my child's COVID-19 vaccine administration information to the Centers for Disease Control and Prevention (CDC) through the Indian Health Service National Data Warehouse to the CDC IZ clearinghouse for mandatory COVID-19 vaccine reporting purposes.

I agree for myself or my child to be monitored for 15-30 minutes after COVID-19 vaccination. I understand the risks associated with not being monitored which include, but are not limited to, severe allergic reaction, fainting or loss of consciousness, motor vehicle crash, and death.

C

For vaccination of minors, please select one:

_____ My child's COVID-19 and/or Influenza immunization can be done **WITHOUT MY PRESENCE**.

_____ My child's COVID-19 and/or Influenza immunization can **ONLY** be done **WITH MY PRESENCE**.

Patient/Guardian's Signature: _____ Date _____ Time _____