The Life Health Center
Wellness is Your Key to Life

Life Health Center COVID Vaccination Form

Patient's Full Name: _____ **Date:** _____

D.O.B _____ / _____ / _____ **Sex:** ☐Male ☐Female **Phone #:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

☐Amer Indian/Alaska Native ☐Asian ☐Black or African Amer ☐Pacific Islander ☐White ☐ Multiracial ☐Hispanic

Insurance:

Insurance Carrier Policy Number **Non Insured: SS#**_____

COVID Vaccination Questionnaire

Have you ever had a positive test for COVID-19 ☐**Yes** / ☐**No** If Yes, When? _____
Is this your FIRST COVID vaccination? ☐**Yes** / ☐**No** If NO, provide the date(s) of your previous Vaccine(s). 1st _____ 2nd _____

YES	NO	Within the PAST two WEEKS
		1. Have you been feeling sick (fever, cough, congestion)? If yes, please explain:
		2. Have you received ANY vaccinations within the last 14 days?
YES	**NO**	Within your LIFETIME
		3. Have you ever had an allergic reaction to any of the following: a. Polyethylene glycol (compound in Miralax laxative) b. Polysorbate (compound in vaccine, coated tablet, intravenous steroid) c. Any Vaccine or Intravenous therapy
		4. Have you had an allergic reaction that required treatment with epinephrine, an EpiPen®, or that caused you to go to the hospital? If Yes, Please explain:
		5. Have you received antibody therapy as treatment for COVID?
		6. Are you pregnant or nursing?

As the parent/guardian of the above named, I understand the benefits and risks of receiving this COVID vaccine and choose to assume this risk for my child. I give my permission for the Life Health Center to administer this vaccination without my presence. I authorize the Life Health Center to provide the vaccine and any associated treatment necessary during the receipt of the vaccine. ***All COVID vaccinations are reported to the DEL VAX.***

Patient/Parent/Guardian's Signature: _____**Date:** _____

Time of Injection	Vaccination	Dose	Site of IM Injection (Deltoid)	Lot #	Exp	VIS & Vsafe APP given	Earliest Date of 2nd Vaccine	Time if you feel OK to leave
	Pfizer	**0.3mL**					**(3wks)**	

Nurses Signature:_____ DATE: _____

The Life Center Complex, Inc.
222 Philadelphia Pike, Suites 13-15 N • Wilmington, DE 19809
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dba The Life Health Center

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Child's Name: _____ DOB: _____

RELEASE OF SCHOOL RECORDS AND GENERAL CONSENT FORM

PLEASE NOTE THIS CONSENT FORM IS VALID AND EFFECTIVE FOR THIS STUDENT THROUGH THE END OF THEIR ENROLLMENT IN THIS SCHOOL UNLESS OTHERWISE REVOKED BY YOU.

This record release authorizes the School District to release to the Life Health Center any Education Records, as defined in the Family Educational Rights and Privacy Act, pertaining to my child, _____. I represent under penalty of perjury that I _____ am the legal guardian or parent. I understand I can revoke this release in writing at any time, but a revocation is not effective until received. In addition, my signature below also authorizes the Life Health Center to work with the above named child in accordance with the directions noted below. This consent is valid for their enrollment at this school.

BY SIGNING BELOW, *I understand that:*

- My child will participate in the Wellness Center's prevention programs which will contain a brief questionnaire, but will NOT receive treatment without me being contacted first.
- The Life Health Center provides services through the School District and all the parties listed as a part of the collaboration can review and share all written and verbal information concerning your child on a need to know basis, including school records, medical records, and clinically appropriate recommendations to School Administrators and Nurses in the best interest of the child and family.
- The Life Health Center will only use or take a picture of my child for identification purposes.
- The Life Health Center School Wellness Program may use telemedicine (video) to provide behavioral and physical health services. If video is used, there will be no recording of the video.
- **The services at the Wellness Center are FREE to you, the parent, but your insurance will be billed if you have insurance. You may have to pay for things done outside of the Wellness Center like prescriptions, labs, and telemedicine visits with other providers.**

Below is a list of services that we offer. If you do **NOT** want your child to get any one of these services, please **CROSS IT OFF** the list.

Physical Health	Behavioral/Emotional Health
• Evaluation and treatment of minor illness or injury • Immunizations and vaccines • General check-ups • Screening for medical problems • COVID testing	• Evaluation for emotional problems • Group couseling and therapy • Individual therapy

What is your child's health insurance? □ None □ Medicaid □ Private

_____

Insurance Carrier Policy Number Group Number

NOTE: The below Parent/Legal Guardian Signature authorizes both the release of School Records to Life Health Center and treatment of this Child by the Life Health Center.

_____

***Signature of Parent/Legal Guardian** **Date**

*For Electronic Senders-Sending this authorization for services form using the Life Health Center website is secured by Caldera Forms and Word Press using a HIPAA compliant encryption program. Please note that sending this form or any other medical form using an unsecured method of delivery can compromise the safety and security of protected medical information. Life Health Center will not accept or be responsible for forms sent using an unsecured method of delivery.

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