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.

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 _____