Vitalink Training Center

Vitalink Training Center is committed to serving the public during the COVID-19 pandemic. One of the most significant way to impact the community and slow the spread of the virus is to get people vaccinated.

Appointment Instructions:

Download and fill out the form to the best of your ability then save the document on your computer. Once complete go to our registration page and upload your intake form. Once registered one of our staff will contact you to set your appointment.

If you have further questions, please check our FAQ, they are updated frequently to give you the most up to date information available to us.

Vitalink Training Center

Insurance Information

Form 1 of 2 to be completed

Plan Name | GRP# | Member ID#

Vaccine Intake Consent Form

Clinic Information

Vitalink Training Center | (754) 222-9769

Clinic Name | Telephone

5873 Margate Boulevard | Margate | FL | 33063

Address | City | State | Zip

Patient Information

Last Name | First Name | Date of Birth | Gender

Address

Primary Care Provider (PCP) Name | PCP Phone Number | PCP Fax Number

PCP Address

If someone else manages health decisions on your behalf, please provide the following:

Caregiver or Financially Responsible Party Name | Relationship | Phone Number

Check all vaccines interested in receiving:

- ☐ Flu
- ☐ Tdap
- ☐ Shingles (Age 50+)
- ☐ Pneumonia Prevnar 13® (Age 65+ or 2-64 with certain medical conditions)
- ☐ Pneumonia Pneumovax 23® (Age 65+ or 2-64 with certain medical conditions or who smoke)

COVID-19 Screening Questions	YES	NO	DON'T KNOW
1. In the past two weeks, have you tested positive for C0VID-19 or are you currently being monitored for C0VID-19?	○	○	○
2. In the past two weeks, have you had contact with anyone who tested positive for C0VID-19?	○	○	○
3. Do you currently or have you in the past 14 days, had a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	○	○	○

To be filled out by the immunizer: Patient Temperature: Date:

If patient answers yes to any of these questions or patient's bodily temperature is 100"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 and that the facility coordinator will be notified.

Last Name First Name Date of Birth

Immunization Screening Questions

	YES	NO	DON'T KNOW
1. Are you sick today? (For example: a cold, fever, or acute illness)			
2. Do you have allergies or reactions to any foods, medications, vaccines, or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.)			
3. Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?			
4. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?			
5. Do you take anticoagulation medication? For example: warfarin, Coumadin, or other blood thinner.			
6. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?			
7. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, or any other immune system problem?			
8. Do you have a weakened immune system or in past 3 months, taken medications that weaken it such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments?			
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?			
10. For women, are you pregnant or is there a chance you could become pregnant during the next month?			
11. Have you received any vaccinations or TB skin test in the past 4 weeks?			

ACKNOWLEDGEMENT: I have been provided with the Vaccine Information Sheet(s) corresponding to the vaccine(s) that I am receiving. I have read the information provided about the vaccine I am to receive, I have had the chance to ask questions that were answered to my satisfaction, I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

I understand I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. If I have had a previous severe reaction to a vaccine, I will be monitored for 30 minutes. I understand if I experience any side effects after leaving the vaccination area, I should call my doctor, or if the side effects are severe, I should call 911.

AUTHORIZATION TO REQUEST PAYMENT: I authorize release of my personal, billing, and medical information to third party payers, insurance companies, or review agencies for use in connection with payment, including eligibility for payment, regulatory or accreditation compliance or as is required for provider to receive payment or reimbursement for care. I authorize and irrevocably assign to the administrator of the vaccine payment of any benefits payable to me/amounts payable for the vaccine I receive.

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: Notwithstanding anything set forth above, I agree that I am responsible for and will promptly pay on demand any and all obligations to Vitalink Training Center, Inc ("VTC") including all self-pay balances as well as those charges for services not covered or disallowed by my insurance carrier.

DISCLOSURE OF RECORDS: I understand that VTC may be required to or may voluntarily disclose my health Information to the physician responsible for this protocol of specific health information of people vaccinated by VTC, (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment, or other health care operations (such as administration or quality assurance). I also understand that VTC will use and disclose my health information as set forth in the VTC Notice of Privacy Practices (copy is available upon request).

I agree that VTC and its business associates may contact me by any phone number provided by me or associated with my health record, including cell phone numbers, which could result in charges to me. VTC also may contact me by sending text messages or emails, using the contact information I provided. Methods of contact may include using pre-recorded /artificial voice messages and/or use of an automatic dialing device.

X

Signature of patient to receive vaccine or person authorized to make the request (parent/guardian) Date

By typing your name in this field you are electronically signing this document.