INDEMNIFICATION AND PERMISSION SHEET

1. In consideration for receiving the opportunity to participate in COVID-19 Vaccination (hereinafter "Vaccination"), which is provided by the company HR Support, Inc. (together, hereinafter "Company"),
2. I _____(herein "Participant') hereby release, waive, discharge, covenant not to sue, and
(First and last name of self if over 18 / parent or legal guardian if under 18)
agree to hold harmless for any and all purposes Company and their healthcare staff, members, shareholders, officers, servants, agents, volunteers, or employees from any and all liabilities, claims, demands, injuries, or damages, including court costs and attorney's fees and expenses, that may be sustained by me while participating in Vaccination, while traveling to and from the Vaccination, or while on the premises owned or leased by the property owner of the vaccination site.
3. I am also fully aware that Company is not providing medical care or giving a medical diagnosis based on the results indicated from Vaccination and that ***I should consult my doctor or go to an emergency room if have any serious symptoms and/or to obtain medical advice as to the results of the Vaccination.*** The Vaccination does not preclude the possibility that I have COVID-19 or that I may develop it in the future, and I am aware I should obtain further testing if I develop any symptoms or come in contact with anyone who may have COVID-19. I choose to voluntarily participate in Vaccination with full knowledge of these facts. I know of no medical reason why I should not participate.
4. To the extent necessary to complete the Vaccination and to allow Company to provide information related to the Vaccination to appropriate government authorities or non-profit entities who are studying COVID-19, I hereby waive my rights regarding protected health information under HIPAA. Protected health information ***will*** not be reused or disclosed by Company to any person or entity other than above, except as required by law.
5. VOLUNTARY SIGNATURE. In signing this agreement I acknowledge and represent that I have read it, understand it, and sign it voluntarily as my own free act and deed; Company has not made and I have not relied on any oral representations, statements, or inducements a part from the terms contained in this agreement.

Please provide the following information for the individual being tested:

*First Name: _____ *Last Name: _____ *Sex: _____*Date of Birth: ____/_____/_____
M / F / Other *MM / DD / YYYY*

Race/Ethnicity: (circle one) American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian & Pacific Islander / White / Unknown / Other

*Residential Address: _____
House Number, Street Name, Apt Number *City* *State* *Zip Code*

Email Address: _____ Mobile Number: (_____)_____-_____

Each person who registers will need to use their own unique email and mobile number in order to receive automated results. By providing your email address and mobile number you consent to receiving messages to the number provided.

Do you have any of the following symptoms? Please check all that apply:

Cough ☐ Chills ☐ Headache ☐ Diarrhea ☐ Shortness of breath or difficulty breathing ☐ Repeated shaking with chills ☐ Sore throat ☐
Vomiting ☐ Fever ☐ Muscle pain ☐ New loss of taste or smell ☐ N/A ☐

Have you been in close contact with someone who tested positive for COVID-19 in the last two weeks? Yes ☐ No ☐

Have you been tested for COVID-19 before? Yes ☐ No ☐

INSURANCE: (circle one) Commercial / Medicaid / Medicare / MediCal / Other / None

Name of Insurance Carrier: _____

Policy or Member Number: _____ Group ID: (If applicable) _____

Policy Holder's Name: _____ Relationship to policy holder: (circle one) Self / Spouse / Minor

Bring a copy of your **School Photo ID*

Bring a copy of your **Insurance Card or by signing below, "I attest that I don't have insurance"*

Signature _____

Date: _____

*Signature or Parent/Legal Guardian Signature: _____ Date: _____