

# COVID-19 VACCINE CONSENT FORM

## Information about person to receive vaccine (please print)

Name: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Race:  Asian  Black  Native American  Pacific Islander  White  Other Ethnicity:  Hispanic  Non-Hispanic

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Do you have insurance?  No  Yes

### The following questions will help determine if there is any reason you should not receive a COVID immunization injection.

Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.

Has the person to be vaccinated ever received a COVID-19 vaccine?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, date: _____ Type/Brand of COVID vaccine: _____	
Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex?	<input type="checkbox"/> No <input type="checkbox"/> Yes
List all allergies: _____	
Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is the person to be vaccinated sick today?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is the person to be vaccinated at least 18 years old?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If no, is the person to be vaccinated at least 16 years old?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has the person to be vaccinated received any other vaccines in the past 14 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19?	<input type="checkbox"/> No <input type="checkbox"/> Yes

I have read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian).

**I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.**

Print Parent/Guardian name, if different from client: \_\_\_\_\_

Client/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### FOR CLINIC USE ONLY

Clinic site: \_\_\_\_\_ EUA Fact Sheet Provided: Yes No

Date vaccine administered: \_\_\_/\_\_\_/\_\_\_ Date booster required: \_\_\_/\_\_\_/\_\_\_

Vaccine manufacturer: \_\_\_\_\_ Lot number: \_\_\_\_\_

Site of IM injection: RDT or LDT or \_\_\_\_\_ Dose: 0.3ml 0.5ml

Signature and title of vaccine administrator: \_\_\_\_\_

Nurse's Comments: \_\_\_\_\_

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## INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Insurance: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Group No: \_\_\_\_\_

Policy No: \_\_\_\_\_

Client's relationship to subscriber: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Group No: \_\_\_\_\_

Policy No: \_\_\_\_\_

Client's relationship to subscriber: \_\_\_\_\_

The above information is true to the best of my knowledge. If qualified, I authorize billing to my insurance company and release of information required to process my claims.

I authorize my insurance benefits be paid directly to Pole Mountain Pharmacy.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_