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? ☐ No ☐Yes

If yes, date/s:_____ _____ Type/Brand of COVID vaccine:_____

Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex? ☐ No ☐Yes

List all allergies: _____

Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy? ☐ No ☐Yes

Is the person to be vaccinated sick today? ☐ No ☐Yes

Is the person to be vaccinated at least 18 years old? ☐ No ☐Yes

If no, is the person to be vaccinated at least 12 years old? ☐ No ☐Yes

Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner? ☐ No ☐Yes

Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19? ☐ No ☐ Yes

Person to be vaccinated attests to having a qualifying moderate/severe immunocompromising condition and/or their healthcare provider has recommended an additional dose of mRNA vaccine ☐ No ☐ 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 received and read the Pole Mountain Pharmacy Notice of Privacy Practices and have had a chance to ask questions about how my information will be used.

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_____