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 Medicare or Medicaid?** ☐No ☐Yes--Number:___________________

Do you have insurance? ☐No ☐Yes Company:_______________ Policy/ID#:______________________________

Please list policyholder name, date of birth & address, if not you: ____

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.

Question		
Has the person to be vaccinated ever received a COVID-19 vaccine?	☐ No	☐Yes
If yes, date(s):______________________________ Type/Brand of COVID vaccine:_______________		
If yes, and if the initial vaccination series is complete, is the person seeking a booster dose? (For 65+ yrs., medical conditions, high-risk occupations, & 6 mo. after the initial series for mRNA, 2 mo. after J&J)	☐ No	☐Yes
Does the person attest to having a qualifying moderate/severe immunocompromising condition? (e.g. cancer treatment, organ transplant, etc.) If yes, it is recommended to receive an additional, full dose at least 28 days after initial series completion.	☐ No	☐Yes
Please indicate the age of the person to be vaccinated:	☐ 18 years or older ☐ 12-17 years old ☐ 5-11 years old	
Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex? List all allergies: ______________________________________	☐ No	☐Yes
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
Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner?	☐ No	☐Yes
Does the person to be vaccinated have a history of myocarditis or pericarditis?	☐ No	☐Yes
Has the person to be vaccinated received passive antibody therapy as a treatment for COVID-19?	☐ No	☐Yes

I have read, or have had explained to me, the Vaccine Information Statement (VIS,) or 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. 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.

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

X Client/Parent Signature: ____ Date: ____________________

Print name if guardian or parent:____________________________________

Clinic site: _____________ ***Date vaccine administered***: ______________ ***Date 2nd dose required*** ____________

EUA Fact Sheet Provided: *Yes No* ***Pfizer*** *0.2ml* ***Pfizer*** *0.3ml* ***Moderna*** *0.5ml* ***Moderna*** *0.25ml* ***J&J*** *0.5ml*

Site of IM injection: *RDT or LDT or* ________ ***Lot number***: _______________________

Signature & title of vaccine administrator: ____

Comments: Billed ☐ WYIR ☐