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.

Has the person to be vaccinated ever received a COVID-19 vaccine? If yes, date of most recent vaccine dose _____ Type/Brand of COVID vaccine: _____	☐ No ☐Yes
Does the person attest to having a qualifying underlying medical condition that increases a person's risk of severe Covid-19? If yes please specify condition(s): _____	☐ No ☐Yes
Please indicate the age of the person to be vaccinated:	☐ 65 years or older ☐ 18-64 years old ☐ 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

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:*** _____

EUA Fact Sheet Provided: *Yes* *No* ***Pfizer Updated Vaccine*** *0.3ml* ***Moderna Updated Vaccine*** *0.5ml*

Site of IM injection: *RDT or LDT* ***Lot number:*** _____

Signature & title of vaccine administrator:_____

Comments:

Billed ☐ WYIR ☐