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 Health 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 had a positive test for COVID-19?	☐ No ☐Yes
Has the person to be vaccinated ever been told by a doctor that they had COVID-19?	☐ No ☐Yes
Has the person to be vaccinated ever received a COVID-19 vaccine?	☐ No ☐Yes
If yes, date:_____ Type/Brand of COVID vaccine:_____	
Is the person to be vaccinated currently pregnant or breastfeeding?	☐ No ☐Yes
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 an allergic reaction to any of the following?	
Polyethylene Glycol ☐ No ☐Yes Polysorbate ☐ No ☐Yes	
A previous dose of COVID-19 vaccine	☐ 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
Is the person to be vaccinated at least 18 years old?	☐ No ☐Yes
If no, is the person to be vaccinated at least 16 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 any other vaccines in the past 14 days?	☐ No ☐Yes
Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19?	☐ No ☐ Yes
Does the person to be vaccinated have a weakened immune system caused by something such as and HIV infection, cancer or the use of immunosuppressive drugs or other therapies?	☐ 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 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: _____

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INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Insurance: _____

Policy Holder's Name:_____ Date of birth: _____

RX BIN Number: _____ PCN Number: _____

Member ID Number: _____ Group Number: _____

Client's relationship to subscriber: _____

Secondary Insurance: _____

Policy Holder's Name:_____ Date of birth: _____

RX BIN Number: _____ PCN Number: _____

Member ID Number: _____ Group Number: _____

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 The Medicine Shoppe in Bloomsburg, PA.

Client Signature_____Date_____

_____**FOR CLINIC USE ONLY AFTER THIS POINT**_____

***Clinic site**: 1000 Market St., Bloomsburg, PA 17814* ***EUA Fact Sheet Provided**: Yes No*

***Vaccine manufacturer**: _____*

***Date First Vaccine Given**: _____/_____/_____*	***Date Booster Vaccine Given**: _____/_____/_____*
***Dose**: 0.3ml 0.5ml* **Lot #**	***Dose**: 0.3ml 0.5ml* **Lot #**
***Site of IM injection**: RDT or LDT or*	***Site of IM injection**: RDT or LDT or*

***Signature and title of vaccine administrator**: _____*