COVID-19 VACCINE CONSENT FORM

Information about person to receive vaccine (please print)

Name: _____ **Birth date (mm/dd/yyyy)**: _____ **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 ☐

Please also submit: Prescription Insurance Card/Medicare Card and Identification Card (such as Driver's License)

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, 1st dose date:_____ 2nd dose date:_____ Type/Brand of COVID vaccine:_____

Does the person to be vaccinated have an allergy to any medications, food, polysorbate 80, HBCD, citric acid monohydrate, trisodium citrate dihydrate, ethanol, sodium chloride, sodium hydroxide,
hydrochloric acid, 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 ☐

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 ☐

Have you tested positive for COVID-19 in the last 90 days? No ☐ Yes ☐

Are you pregnant or breast feeding? No ☐ Yes ☐

Do you have dermal fillers? No ☐ Yes ☐

Do you have any underlying health conditions:_____

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 NOTIFIED OF THE REQUIRED 15-30 MINUTES OBSERVATION AFTER RECEIVING MY IMMUNIZATION.

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 Northwest Hills Pharmacy at Davenport.

Print Parent/Guardian name, if different from client: _____ Client/Parent/Guardian

Signature: _____Date (mm/dd/yyyy): _____

FOR CLINIC USE ONLY

***Clinic site**: Northwest Hills Pharmacy at Davenport* ***EUA Fact Sheet Provided**: Yes No*

***Date vaccine administered**: ____/____/_____*

***Vaccine manufacturer**: **Lot number**: _____*

***Site of IM injection**: RDT or LDT or _____ **Dose**: 0.5ml*

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

***Provider's Comments**: _____*