IMMUNIZATION INFORMED CONSENT

COVID 19 Vaccine Consent Form

First Name *MI* *Last Name*

Cell Phone *Date of Birth (mm/dd/yyyy)* *Age* *M F Gender*

Home Address *City* *State* *Zip Code*

Email Address *Driver's License(preferred) OR SS# (need for billing for uninsured)*

___ American Indian or Alaska Native; ___ Native Hawaiian or Pacific Islander; ___Asian; ___ Black/African American; ___ White; ___Hispanic/Latino; ___Other

Please, answer the following questions	Yes	No	Unsure
1. Do you have a fever or illness today?	___	___	___
2. Have you experienced any of the following in the past 14 days: fever, unusual cough, unusual shortness of breath?	___	___	___
3. Have you or a household contact been diagnosed with COVID-19 in the past 14 days?	___	___	___
4. Do you have allergies to medications, food (e.g. eggs), latex, or a vaccine component (e.g. bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol or thimerosal)?. If yes, please list the allergies:	___	___	___
5. Have you received any vaccinations in the past 14-days?	___	___	___
6. Have you ever had a serious reaction to a vaccine in the past?	___	___	___
7. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?	___	___	___
8. Do you have a chronic condition or long-term health problem**? If yes, please check all that apply.** ___Anemia ___Asthma ___Diabetes ___Heart disease ___Kidney disease ___Liver disease ___Lung disease ___Obesity	___	___	___
9. **For women**: Are you pregnant or considering becoming pregnant in the next month?	___	___	___
10. For the past 3 months, have you taken medications that affect your immune system, such as prednisone or other steroids, anti-cancer drugs, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis; or have you had radiation treatments?	___	___	___
11. Do you have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?	___	___	___

I have received a Notice of Privacy Practice for HIPAA. I have read, or have had read to me, the EUA information for the COVID vaccine I am receiving I have been able to ask questions about the vaccine, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine. I consent to the administration of the vaccine requested. I understand that the vaccination information will be shared with the state immunization database. **I agree to stay in the general area for 15-30 minutes** after receiving my vaccination in case any immediate reactions occur. If I experience any side effects, I am responsible for following up with my physician at my expense. On behalf of myself, my heirs, and my personal representatives, I hereby release the pharmacy that is administering the vaccine(s); the subsidiaries and affiliates of the pharmacy; the respective directors, officers, employees, and agents of the pharmacy and its subsidiaries and affiliates; and the owner and/or operator of the clinic site and its directors, officers, employees, and agents from any and all liability that might arise from this vaccination.

Patient Signature_____**Date**_____

Vaccine Provided Today: **COVID-19 Vaccine: Manufacturer**_____**First Dose** _____ **Second Dose** _____

Allison Cardona NPI 1457753394 *Emma-Leigh Whitaker NPI* 1649771312 *Jamie Williams NPI* 1326423385

Lot: _____

Exp Date: _____

IM Admin Site: Right Arm ___ ***Left Arm*** ___ ***Vaccinator*** _____

EUA Form given ___ ***Immunization Card Given*** ___ ***Title*** _____

By signing as administrator you are confirming that contraindications and side effects have been reviewed and a current VIS was provided to the patient receiving the vaccine.