COVID-19 VACCINATION CONSENT FORM

PATIENT INFORMATION

Legal First Name		**Last Name**			
Date of Birth	**Gender**	**Mother's Maiden Name**		**Race / Ethnicity**	
Address	**City**	**County**	**State**	**Zip**	**Phone**
Health Insurance Company		**Email Address**			
Insurance ID # or Member #		**Insurance Policy Holder Name & DOB:**			

Please complete the questions below for yourself or the person receiving the vaccination

Are you between the ages of 5 and 11 years old? Age:_____	☐ No ☐ Yes
Are you feeling sick today?	☐ No ☐ Yes
Have you been tested for Covid -19 in the past 72 hours or awaiting results from a Covid test?	☐ No ☐ Yes
Have you been treated with antibody therapy or plasma in past 90 days?	☐ No ☐ Yes
Do you have a medical condition that has weakened your immune system ie. (HIV,AIDS, Cancer etc)	☐ No ☐ Yes
Have you ever received a dose of the COVID-19 vaccine?	☐ No ☐ Yes
Have you ever had an allergic reaction to another vaccine or injectable medication?	☐ No ☐ Yes
Have you received any other vaccine in the last 4 weeks?	☐ No ☐ Yes
Are you currently on a high dose of steroids?	☐ No ☐ Yes
Do you have a history of myocarditis or pericarditis?	☐ No ☐ Yes
Have you taken an antiviral medication within the last 48 hours?	☐ No ☐ Yes
Do you have a bleeding disorder or are you taking a blood thinner?	☐ No ☐ Yes
Do you have any questions for the nurse?	☐ No ☐ Yes

PLEASE SIGN BELOW

COVID-19 Consent

I have read, or had explained to me, the Vaccination Information Statement about *COVID-19* vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the *COVID-19* vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.

*The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic.

X _____

Signature of Recipient (Parent or Guardian) Date

X _____

Signature of Recipient (Parent or Guardian) Date

TO BE COMPLETED BY NURSE:

Administration Date:

Dose #1: _____

Dose #2: _____

Administration Site:

Dose #1: ☐ **Left Deltoid** ☐ **Right Deltoid**

Dose #2: ☐ **Left Deltoid** ☐ **Right Deltoid**

Dosage:

Dose #1: ☐ **0.2 ml**

Dose #2: ☐ **0.2 ml**

#1	#2
Manufacturer: _____	**Manufacturer:**_____
Lot Number: _____	**Lot Number:** _____
Expiration Date: _____	**Expiration Date:**_____

Next Immunization Due:

☐ **In 3 weeks (_____)**

Nurse Signature Dose #1: _____

Nurse Signature Dose #2: _____

PFIZER: CHILDREN AGED 5-11 YEARS OLD