COVID-19 VACCINE CONSENT FORM

Please complete form with information about the person who is receiving the vaccine (please print)

Clinic Use: M12+ M6-11 M<6
JJ Nvx Pf12+ Pf5-11 Pf<5
Dose: 1st 2nd Add'l Bstr 1 Bstr 2

Name: _____ **Birth Date**: _____ **Age**: _____ **Sex**: ☐M ☐F ☐Other

Race: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other **Ethnicity**: ☐Hispanic ☐Non-Hispanic

Mailing 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.

How many doses of a COVID-19 vaccine have you received? ☐0 doses ☐1 dose ☐2 doses ☐3 doses ☐4 doses Date of dose 1:_____ Date of dose 2:_____ Date of dose 3:_____ Date of dose 4:_____ Type of dose 1:_____ Type of dose 2:_____ Type of dose 3:_____ Type of dose 4:_____	
Do you have a moderate/severe immunocompromising condition? (for example, cancer treatment, organ transplant, etc.)	☐ No ☐Yes
Do you have an allergy to any medications, food, vaccine, or latex? List all allergies: _____	☐ No ☐Yes
Have you ever had a severe reaction to any vaccine or injectable therapy?	☐ No ☐Yes
Are you sick today?	☐ No ☐Yes
Do you have a bleeding disorder or are you taking a blood thinner?	☐ No ☐Yes
Do you have a history of myocarditis or pericarditis?	☐ No ☐Yes

By signing below, I consent to the _____ County Public Health Office (PHN) administering the current vaccinations to me. In addition, I read or have had explained to me and understand the Vaccine Information Statement(s) or the Emergency Use Authorization Fact Sheet(s) for the vaccine(s) that the PHN is administering today. A healthcare professional also provided education and counseling on each vaccine and thoroughly answered my questions. **I HAVE BEEN ADVISED TO WAIT FOR 15 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.**

Client/Guardian Signature: _____Date_____

Billing Authorization

By signing below, I authorize the PHN to bill my insurance company for the vaccine(s) administered to me. I also authorize the PHN to disclose my protected health information to my insurance company for payment purposes. I authorize my insurance benefits to be paid directly to the PHN.

Client Signature: _____Date_____

Receipt of the Notice of Privacy Practices:

The Notice of Privacy Practices explains how WDH may use or disclose information. Not all situations may be described. WDH is required to furnish its clients with a notice of privacy practices pertaining to information we use, maintain and disclose.
I have received a copy of the WDH Notice of Privacy Practices and have had an opportunity to ask questions regarding how my information will be used.

By signing below, I acknowledge receipt of the Notice of Privacy Practices.

Client Signature: _____Date_____

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Clinic site**:* _____ ***Date of vaccine**:* _____ ***Date next dose due: _____

***Dose**:* ☐Pfzr 3mcg/0.2ml (6m-4y) ☐Pfzr 10mcg/0.2ml (5-11y) ☐Pfzr 30mcg/0.3ml (12+y) ☐Pfzr BiV. Bstr 30mcg/0.3ml (12+y)
☐Pfzr BiV. Bstr 3mcg/0.2ml (6m-4y) (3rd dose of primary series) ☐Pfzr BiV. Bstr 10mcg/0.2ml (5-11y)

☐M 25mcg/0.25ml (6m-5y) ☐M 50mcg/0.5ml (6-11y) ☐M 100mcg/0.5ml (12+y) ☐M BiV. Bstr 50mcg/0.5ml (12+yrs)
☐M BiV. Bstr 10mcg/0.2ml (6m-5y) ☐M BiV. Bstr 25mcg/0.25ml (6-11y)

☐J&J 0.5ml (18+yrs) ☐Nvx 0.5ml (12+yrs) ☐Nvx Bstr 0.5ml (18+yrs)

***Site of IM injection**:* ☐RDT ☐LDT ☐RVL ☐LVL ***VIS/EUA Fact Sheet Provided**: Yes No* ***Lot number**:* _____

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

Comments:

Billed☐ WYIR☐