COVID Vaccine Informed Consent

Section 1 – Patient Information

First Name:_____ Last Name: _____M.I:_____Gender: M ☐ F ☐

DOB:_____ Age:_____ Mother's Maiden Name: _____

Phone:_____ Email:_____.

Home Address:_____City:_____State:_____ Zip code: _____.
Race: White☐ Asian☐ Black☐ Pacific Islander☐ Native American ☐ Other ☐ Hispanic/Latino?: Y ☐ N ☐

Section 2 – Screening Questions Y=Yes, N=No

1. Do you feel sick today with moderate to severe symptoms? Y ☐ N ☐
2. Do you have a fever? Y ☐ N ☐
3. Have you ever received a dose of COVID-19 vaccine? Y ☐ N ☐
4. Have you received another vaccine (any type) within the past 14 days? Y ☐ N ☐
5. Do you have a severe bleeding disorder? Y ☐ N ☐
6. Have you had a serious allergic reaction (such as anaphylaxis) to any component of a Covid-19 vaccine? Y ☐ N ☐
7. Have you received monoclonal antibodies or convalescent serum in the last 90 days? Y ☐ N ☐
8. Have you ever had a severe allergic reaction (such as anaphylaxis)? Y ☐ N ☐
9. Are you immunocompromised? Y ☐ N ☐
10. **For women:** Are you pregnant or considering becoming pregnant within a month? Y ☐ N ☐
11. Are you breastfeeding? Y ☐ N ☐

Section 3 – Health Insurance Do you have health insurance? Y ☐ N ☐

Insurance Co. Name:_____ ID Number:_____

Subscriber's Name _____Subscriber's Birth Date: _____

Section 4 – Consent for Treatment and Privacy Notice

I certify that the information I have provided is true and accurate. I, or the minor for whom I represent and am authorized to sign the consent, have had a chance to review the Covid-19 vaccine Information (EUA Fact Sheet) and have had a chance to ask questions, which have been answered to my satisfaction and understand the risks & benefits of the vaccine. I consent to receive the vaccine and have been advised to wait or approximately 15 minutes after vaccine administration for observation. I understand and agree that information related to my vaccine administration may be shared with other health care professionals and recorded in the Utah Statewide Immunization Information System (USIIS) and any other medical information may be used to process an insurance claim. I understand I am responsible for copays or if payment is denied by my insurance carrier.

Signature:_____ Date: _____

Relationship tent: Self ☐ Parent ☐ Legal Guardian ☐ Other ☐ _____

Section 5 – Pharmacy Use

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Date	Manufacturer	Lot Number	Expiration	Dose	Route	Site	Vaccinator
					IM	☐ **Right Deltoid** ☐ **Left Deltoid**	