COVID Immunization Consent Form

Name: _____ Date of Birth: _____ Age: _____ Gender: Male/Female

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Social Security Number (*full social is required*): _____

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ Native Hawaiian/other pacific islander
☐ Native American ☐ Alaska Native ☐ Asian ☐ Other

MEDICAL HISTORY: Please complete the following questions for the individual receiving the vaccine.

Have you had a previous COVID-19 vaccine? If so, what was the date?	YES	NO
Have you had any vaccines within the previous 14 days?	YES	NO
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?	YES	NO
Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component, or injectable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness, and/or weakness.	YES	NO
Are you pregnant, breastfeeding, or planning to become pregnant?	YES	NO
Are you immunocompromised or have HIV, cancer, chronic kidney disease, lung, heart disease, sickle cell, severe obesity, have diabetes? Are you receiving any immunosuppressive therapy? Do you smoke?	YES	NO
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? **Current COVID-19 vaccines MUST be deferred for **at least 90 days** to avoid interference of treatment with vaccine-induced immune responses.**	YES	NO
NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine may be due in 21 days or 28 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Keep your COVID-19 vaccination record card for your records for proof of initial vaccination date.		

RELEASE AND ASSIGNMENT:

- I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EAU) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for each vaccine, visit the website www.cdcvaccine.com: or you may also visit the Local Health Unit or private provider to receive a printed copy of the EUA Fact Sheet.
- I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine.
- I hereby acknowledge that I have received a copy of the Provider's Privacy Notice.
- I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.

To My Insurance Carriers:

- I authorize the release of any medical information necessary to process my insurance claim(s).
- I authorize and request payment of medical benefits directly to this COVID-19 Provider.
- I agree that authorization will cover all medical services rendered until I revoke authorization.
- I agree that the photocopy of this form may be used instead of the original.

My signature below indicates I have read, understand, and agree to the Release and Assignment section of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).

Signature of Patient or Guardian: x _____ Date: _____

BELOW IS FOR PHARMACY DOCUMENTATION

ULTRA-COLD		FROZEN		REFRIGERATED	
☐ Pfizer BioNTech		☐ Moderna		☐ AstraZeneca ☐ Janssen ☐ Novovax-Matrix-M1 ☐ Other _____	
ROUTE	SITE CODE	DOSAGE ML	MFG CODE	LOT NUMBER	EXPIRATION DATE
MFG Codes: PFR = Pfizer, MOD = Moderna, ASZ = AstraZeneca, JSN = Janssen, NVX = Novavax, MSD = Merck Site Codes: right deltoid = RD, left deltoid = LD					

Administered by: _____ Title: _____ Date Given: _____