

COVID-19 VACCINE CONSENT FORM**Patient Information**

Full Name: _____ **Birth date:** ____/____/____

SSN: ____ - ____ - ____ **Phone:** _____

Address on File with Insurance/Medicare: **Street** _____

City/State _____, **ZIP** _____

Do you have insurance? No Yes

Medicare Information

(Please fill in even if you have a Medicare Advantage Plan)

Medicare # _____

Name as it appears on your

Medicare Card (Red, White and Blue card): _____

INSURANCE INFORMATION

(Please bring ALL insurance cards to appointment)

Prescription Insurance Carrier: _____

Cardholder's Name: _____

Group No: _____

Policy No: _____

Relationship to cardholder: _____

Other Insurance: _____

Cardholder's Name: _____

Group No: _____

Policy No: _____

Relationship to cardholder: _____

The above information is true to the best of my knowledge. If qualified, I authorize billing to my insurance company and release of information required to process my claims.

I authorize my insurance benefits be paid directly to Phoebe Services Pharmacy.

Print Name, if different from patient: _____ **Relationship:** _____

Patient/POA Signature: _____ **Date:** _____

COVID-19 VACCINE CONSENT FORM

Covid Vaccine Intake Information

Name: _____ **Temp:** _____
Sex: Male Female **Birth date:** ____/____/____
Race: Asian Black Native American Pacific Islander White Other **Ethnicity:** Hispanic Non-Hispanic
Type: Resident Healthcare Employee Volunteer Other: _____

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.*

Has the person to be vaccinated ever received a COVID-19 vaccine? No Yes
 If Yes, Circle One: Janssen Pfizer Moderna How many doses: _____
 Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex? No Yes
 List all allergies: _____
 Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy? No Yes
 Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner? No Yes
 Has the person to be vaccinated received any other vaccines in the past 14 days? No Yes
 Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19? No Yes

I have read, or have had explained to me, the Emergency Use Authorization (EUA) or Vaccine Information Sheet (VIS) for the COVID-19 vaccine I am receiving. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

Print Name, if different from patient: _____ Relationship: _____

Patient/POA Signature: _____ Date: _____

FOR CLINIC USE ONLY

Clinic site: _____ **EUA/VIS Fact Sheet Provided:** Yes No

Date vaccine administered: ____/____/____ **Vaccine manufacturer:** _____

Dose #: _____ **Lot number:** _____

Site of IM injection: RDT or LDT **Dose:** 0.3ml 0.5ml

Signature and title of vaccine administrator: _____