

COVID-19 VACCINATION CONSENT FORM
PATIENT INFORMATION

Legal First Name		Last Name				
Date of Birth	Gender	Mother's Maiden Name				
Address	City	County	State	Zip	Phone	
Health Insurance Company		Email Address				
Insurance ID # or Member #		Employer Name				

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

<u>Are you feeling sick today?</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<u>Have you ever received a dose of the COVID-19 vaccine?</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<u>Have you ever had an allergic reaction to another vaccine or injectable medication?</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<u>Have you received any other vaccine in the last 4 weeks?</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<u>Are you currently on a high dose of steroids?</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<u>Do you have a history of Guillain-Barre Syndrome? (Illness associated with the swine flu in 1976)</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<u>If you are female, are you pregnant?</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<u>Have you taken an antiviral medication within the last 48 hours?</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<u>Do you have a bleeding disorder or are you taking a blood thinner?</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes

PLEASE SIGN BELOW
TO BE COMPLETED BY NURSE:

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. X _____ Signature of Recipient (Parent or Guardian) Date	Administration Date: Dose #1: _____ Dose #2: _____	
	Administration Site: Dose #1: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid Dose #2: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid	
	Dosage: Dose #1: <input type="checkbox"/> 0.3 ml Dose #2: <input type="checkbox"/> 0.3 ml	
	#1 Manufacturer: _____ Lot Number: _____ Expiration Date: _____	#2 Manufacturer: _____ Lot Number: _____ Expiration Date: _____
	Next Immunization Due: <input type="checkbox"/> In 3 weeks (_____)	
	Nurse Signature Dose #1: _____ Nurse Signature Dose #2: _____	

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