

COVID-19 Vaccine Consent Form

Section 1: Information about Person to Receive Vaccine (please print)

Resident

Staff

NAME (Last)		(First)	(M.I.)	DATE OF BIRTH	
				month	day
				year	
AUTHORIZED POWER OF ATTORNEY (POA) /LEGAL GUARDIAN NAME (Last)		(First)	(M.I.)	AGE	GENDER
					<input type="checkbox"/> M / <input type="checkbox"/> F
CITY		STATE	ZIP	AUTHORIZED POA PHONE NUMBER:	
PRIMARY CARE PROVIDER'S NAME (Last)			(First)	(Middle Initial)	
FACILITY NAME			ROOM NUMBER		

FOR STAFF receiving COVID-19 Vaccination, please complete the following information.

Check here if uninsured

Drug Insurance Co.

ID#

PH #

Group #

BIN#

PCN#

Primary Cardholder? Yes

No

Primary Name

Primary DOB

Section 2: Screening for Vaccine Eligibility

1. Has this person been vaccinated with the COVID-19 vaccine?

YES NO

If yes to above, there are multiple kinds of COVID-19 vaccine. Your answers to the following questions will help us understand which vaccine (or step) to provide.

Vaccine Brand (Pfizer, Moderna, Astra Zeneca, Johnson and Johnson): _____

Date dose #1 given: Month _____ Day _____ Year _____

Date dose #2 (if necc) given: Month _____ Day _____ Year _____

Section 3: Consent

I have read or had explained to me the Emergency Use Authorization Fact Sheet or a Vaccine Information Statement for the Covid-19 vaccine and understand the risks and benefits.

I GIVE CONSENT to the _____ NAME OF ORGANIZATION CONDUCTING CLINIC and its staff for my person named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then this person will not be vaccinated)

I DO NOT GIVE CONSENT to the _____ NAME OF ORGANIZATION CONDUCTING CLINIC and its staff for this person named at the top of this form to be vaccinated with this vaccine.

Resident signature OR Signature/Printed Name of Health POA OR Name of Health POA/verbally acknowledged by licensed staff (sign & print name & credentials)

Date: Month _____ Day _____ Year _____