COVID-19 VACCINE CONSENT FORM

Name: _____ **Birth date**: ___/___/_____ **Sex**: ☐ Male ☐ Female

SSN: __ __ __-__ __-__ __ __ __ **Phone**: _____ **Do you have insurance?** ☐ No ☐ Yes

Race: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other **Ethnicity**: ☐Hispanic ☐Non-Hispanic

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

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, date:_____ Type/Brand of COVID vaccine:_____		
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) for COVID-19 vaccine. 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 Fact Sheet Provided***: *Yes No*

Date vaccine administered: ____/____/_____ ***Date booster required***: ____/_____/_____

Vaccine manufacturer: _____ ***Lot number***: _____

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

Signature and title of vaccine administrator: _____

PHOEBE PHARMACY

COVID-19 VACCINE CONSENT FORM

Patient Information

Name: _____ **Birth date**: ___/___/_____

INSURANCE INFORMATION

Medicare Part B Information

Medicare # _____

Address on file with Medicare _____
(if different from Primary Address)

Pharmacy Insurance Information

Prescription Insurance: _____

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: _____