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: _____

PHOEBE PHARMACY

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: _____

PHOEBE PHARMACY