COVID-19 VACCINE CONSENT FORM

Information about person to receive vaccine (please print)

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

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

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

Phone: _____ **Do you have Medicare?** ☐No ☐Yes Number:_____

Do you have insurance? ☐No ☐Yes Company:_____ Policy/ID#:_____

Please list policyholder name, date of birth & address, if not you: _____

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? **If yes, date:_____ Type/Brand of COVID vaccine:_____**	**☐ No**	**☐Yes**
Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex? **List all allergies: _____**	**☐ No**	**☐Yes**
Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy?	**☐ No**	**☐Yes**
Is the person to be vaccinated sick today?	**☐ No**	**☐Yes**
Is the person to be vaccinated younger than 18 years old?	**☐ No**	**☐Yes**
If yes, is the person to be vaccinated younger than 16 years old?	**☐ No**	**☐Yes**
Has the person to be vaccinated received any other vaccines in the past 14 days?	**☐ No**	**☐Yes**
Is the person to be vaccinated pregnant?	**☐ 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 (parent or guardian). I have received and read the Wyoming Department of Health Notice of Privacy Practices and have had a chance to ask questions about how my information will be used. 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 Uinta County Public Health.

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

X Client Signature: _____Date: _____

Print name if guardian or parent:_____

FOR CLINIC USE ONLY

Clinic site: _____ ***EUA Fact Sheet Provided***: (*Yes*) *No*

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

Vaccine manufacturer: ____*MODERNA*_____ ***Lot number***: _____

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

Signature and title of vaccine administrator: _____

Nurse's Comments: _____

Billed☐ WYIR☐