COVID-19 VACCINE CONSENT FORM

Please complete form with information about the person who is receiving the vaccine (please print)

Clinic Use: M12+ M6-11 M<6 JJ Pf12+ Pf5-11 Pf<5
Dose: 1st 2nd Add'l Bstr 1 Bstr 2

Name: ________________________________ **Birth Date**: ____________ **Age**: ________ **Sex**: ☐ Male ☐ Female

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

Mailing Address: ________________________________ **City**: ____________________ **State**: _____ **Zip**: ________

Phone: ____________________ **Do you have Medicare or Medicaid?** ☐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.

How many doses of a COVID-19 vaccine have you received? ☐0 doses ☐1 dose ☐2 doses ☐3 doses ☐4 doses

Date of dose 1:__________ Date of dose 2:__________ Date of dose 3:__________ Date of dose 4:__________

Type of dose 1:__________ Type of dose 2:__________ Type of dose 3:__________ Type of dose 4:__________

Question	No	Yes
Do you have a moderate/severe immunocompromising condition? (for example, cancer treatment, organ transplant, etc.)	☐ No	☐Yes
Do you have an allergy to any medications, food, vaccine, or latex? List all allergies: ________________________________	☐ No	☐Yes
Have you ever had a severe reaction to any vaccine or injectable therapy?	☐ No	☐Yes
Are you sick today?	☐ No	☐Yes
Do you have a bleeding disorder or are you taking a blood thinner?	☐ No	☐Yes
Do you have a history of myocarditis or pericarditis?	☐ No	☐Yes

I have read, or have had explained to me, the Vaccine Information Statement (VIS,) or 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. 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 ____________ County Public Health.

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

X Client/Parent/Guardian Signature: ____ Date: ______________

Client/Parent/Guardian Name (printed): ____

Clinic site: ______________ ***Date of vaccine***: ______________ ***Date next dose due***: ____________________

Dose: ☐Pfzr 3mcg/0.2ml (6m-4y) ☐Pfzr 10mcg/0.2ml (5-11y) ☐Pfzr 30mcg/0.3ml (12+y) ☐J&J 0.5ml (18+yrs)
☐M 25mcg/0.25ml (6m-5y) ☐M 50mcg/0.5ml (6-11y) ☐M 100mcg/0.5ml (12+y) ☐M Booster 50mcg/0.25ml (18+yrs)

Site of IM injection: ☐RDT ☐LDT ☐RVL ☐LVL ***VIS/EUA Fact Sheet Provided***: *Yes* *No* ***Lot number***: ____________________

Signature & title of vaccine administrator: ____

Comments:

Billed ☐ WYIR ☐