COVID-19 VACCINE CONSENT AND ADMINISTRATION RECORD

Please complete all requested patient information by filling in the blank or circling the correct letter or code:

Last Name	First Name	**Sex** F M	Date of Birth

Patient Race (Circle One		**Patient Ethnicity (Circle One)**
AI/AN - American Indian or Alaska Native	**O - Other Race**	**HL -Hispanic or Latino**
AS - Asian	**POL - Unable to Report due to Policy/Law**	**NH (Not Hispanic or Latino)**
B/AA - Black or African American	**UNK - Unknown**	**UNK**
NH/PI - Native Hawaiian or Pacific Islander	**W - White**	**POL**

Mothers maiden name (last)	**Primary Care Physician**	**Patient Type**

Facility name where vaccine given	Address (If Healthcare worker - home address	County	Zip Code

Healthcare Worker Contact Phone	**Healthcare Worker E Mail**

Prescription Insurance: **Are you the Primary Cardholder? Yes No If No, Include the Primary Cardholder's DOB** _____

Prescription Benefit Plan Name	Cardholder ID#	Rx Group ID	BIN	PCN

Medicare Fields: Is the Patient age 65 or older or Medicare Eligible? Yes No

Medicare Part A/B ID Number (MBI): _____

Note: MBI is required for all patients age 65 and older, or Medicare eligible. Refer to your Medicare Red, White and Blue Card.

Uninsured Vaccine Recipients - Please provide SS# _____ - _____ - _____ or Driver's License #_____

You should not receive immunization(s) if any of the following apply on the day of administration: You are feeling ill, like having a head -cold, chest congestion or fever. You have had a serious allergic reaction to a previous vaccine or you have history of Guillain-Barre Syndrome (GBS). You have been treated for COVID-19 with intravenous (IV) Monoclonal Antibody (MAB) therapy within the past 90 days or are still recovering from a recent COVID-19 infection and had to use fever controlling medicactions within the past 24 hours.

Please answer the following questions by circling the correct answer:	Dose 1	Dose 2	Dose 3	Dose 4
Have you received IV Monoclonal Antibody (MAB) treatment for COVID-19 in the past 90 days?	Yes No	Yes No	Yes No	Yes No
Have you had a positive COVID-19 test result	Yes No	Yes No	Yes No	Yes No
Are you still experiencing symptions from a recent COVID-19 infection?	Yes No	Yes No	Yes No	Yes No
Have you ever had a severe reaction to a vaccination?	Yes No	Yes No	Yes No	Yes No
Are you allergic to latex?	Yes No	Yes No	Yes No	Yes No
Are you ill today?	Yes No	Yes No	Yes No	Yes No

Circle any known conditions you have: Asthma Blood Disorder Cancer COPD Dementia
Heart Disease High Blood Pressure Immunocompromised Kidney Disease Liver Disease Obesity Pregnant

Consent for Services, Medical Records and HIPPAA Privacy Information

I voluntarily request and consent to receive COVID-19 Vaccine. I acknowledge that I have been given a copy of the Vaccine Informatin or Emergency Use Authorization Sheet that contains informatin about the Vaccine including information on certain adverse reactions I may experience as a result of receiving the Vaccine, and I have carefully read and understand the Vaccine Information Sheet and my questions have been answered to my satisfaction. I have truthfully answered all questions regarding my medical history that are listed above. I understand that I answered a question with a "Yes" there is an increased likelihood that I will experience an adverve reaction from the administration of the Vaccine. After careful consideration, I believe that benefits of receiving the Vaccine outweight the risks associated with receiving the Vaccine and I have decided to receive the Vaccine. I authorize the facility pharmacy to use and/or disclose such information about me, including any medical related informatin necessary to carry out my treatment or conduct its health care operations. This authorization includes disclosures to regulatory agencies, Medicare, Medicaid, Health plan, pharmacy benefit managers, claims processors, billing companies, interpreters, other persons involved in my treatment, as well as any state immunization registry.The facility/ pharmacy shall not, at any time, to the extent allowable by applicable law be liable, responsible, or any way be accountable for any loss, injury, death damage suffered or sustained by me or any person at any time in connection with, or as a result of, the administration of Vaccine, I, for myself, heirs, executors, personal representatives and assigns, hereby release the facility and pharmacy, its way related to my receipt of the Vaccine as allowed by applicable law. By signing below, I certify that I am the patient or patient's guardian/personal representative signing on behalf of the patient, and that I have read, understand and agree to all the statements on this form.

I hereby request the Vaccine for COVID-19 to be given to myself or the person for whom I am authorized to give consent

_____

Signature Patient/Responsible Party Relationship Date