COVID-19 VACCINE IMMUNIZATION CONSENT FORM

LAST NAME:_____ FIRST NAME:_____ MI: _____

SSN: _____ DATE OF BIRTH: ____/____/____ PHONE: _____

ADDRESS: _____ ZIP: _____

MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine.

**If YES and further guidance is needed, refer to Pfizer website at www.PfizerMedInfo.com or call 1-800-438-1985 or Moderna website at* www.modernatx.com *or call 1-866-MODERNA.*	***YES**	**NO**
Have you had a previous COVID-19 vaccine? If yes, include date.		
Have you had any vaccines within the previous 14 days? Pfizer-BioNTech or Moderna COVID-19 vaccine should be administered alone with minimal interval of 14 days before or after any other vaccine.		
Are you sick today or feverish?		
Have you had COVID-19 infection and or are currently in quarantine or isolation for exposure? If so, include date.		
Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component, or injectable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness, and weakness.		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? COVID-19 vaccine should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune responses.		
Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obesity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy?		
WOMEN ONLY: Are you pregnant, breastfeeding or planning to become pregnant? You should a discussion with your healthcare provider can help make informed decision.		

NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine may be due in 21 days or 28 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date.

RELEASE AND ASSIGNMENT:

•I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for each vaccine visit the website www.cvdvaccine.com: or you may also visit the Local Health Unit or private provider to receive a printed copy of the EUA Fact Sheet.
•I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine.
•I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice.
•I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.

To My Insurance Carrier(s):

•I authorize the release of any medical information necessary to process my insurance claim(s).
•I authorize and request payment of medical benefits directly to this COVID-19 Provider.
•I agree that the authorization will cover all medical services rendered until I revoke the authorization.
•I agree that the photocopy of this form may be used instead of the original.

INSURANCE: Please provide a copy of your card or fill out information below:

Medicare B#_____

Rx BIN: _____ Rx ID: _____

Rx PCN: _____ Rx Group: _____

My signature below indicates I have read, understood, and agreed to the ***RELEASE AND ASSIGNMENT*** of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).

SIGNATURE OF PATIENT/GUARDIAN:_____ **DATE:** ____/____/____

☐ Pfizer- BioNTech ☐ Moderna ☐ Other_____ **SHOT SITE:** RD / LD **ROUTE:** IM **LOT #**_____

ADMINISTERED BY: _____ **DATE:** ____/____/____ **EXP:** _____