COVID-19 VACCINE CONSENT FORM

Last Name	First Name	MI	Date of Birth	Age	Gender (at birth)

Address	City	State	Zip	Phone#

Race (optional): ☐White ☐Black/African American ☐Hispanic ☐ Asian ☐Am. Indian/Alaska Native ☐Native Hawaiian ☐Other Pacific Islander ☐ I prefer not to answer

Ethnicity (optional): ☐Not of Hispanic/Latino Origin ☐Hispanic/Latino Origin ☐ I prefer not to answer

Employer Name:____________________________**Email:**____

Do you have insurance? ☐ Yes ☐No Primary Insurance Name: ____________________________

ID#___________________________________Group#: _____________________________

Plan Type: ☐ Commercial ☐ Medicaid ☐ Medicare/Med Advantage, if you have Med Advantage Plan we also need your Medicare ID#_________________________

Insured Name: ☐ Self___________________________DOB:____________Relationship:_______________

The following questions will help determine if there is any reason you should not receive a COVID immunization injection.

Question	No	Yes
Have you ever received a COVID-19 vaccine?	☐ No	☐ Yes
If yes, date:______________ Type/Brand of COVID vaccine:___________________		
Have you ever had a severe allergic reaction (anaphylaxis) to any vaccine or injectable therapy?	☐ No	☐ Yes
Are you currently sick today?	☐ No	☐ Yes
Do you have a bleeding disorder or are they taking a blood thinner?	☐ No	☐ Yes
Have you received any other vaccines in the past 14 days?	☐ No	☐ Yes
Have you received passive antibody therapy as treatment for COVID-19?	☐ No	☐ Yes
Have you been diagnosed with COVID-19 infection in the past 90 days?	☐ No	☐ Yes
For women only, are you pregnant or currently breastfeeding?	☐ 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). 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 HAVE BEEN ADVISED TO WAIT FOR 15 MINUTES (30 MIN IF I HAVE A HISTORY OF ANAPHYLAXIS) OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

Client/Parent/Guardian Signature: _________________________________Date: ______________

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AREA BELOW FOR CLINIC USE ONLY

Clinic site: ________Cascade Health________________________________

Vaccine Mfg.	*Administration Date*	*Vaccination #*	*Dose*	*EUA Fact Sheet Provided*	*Lot #*	*Exp Date*
Pfizer	____/_____/_____	☐ *First Dose* ☐ *Second Dose*	0.3mL ≥ 16 yrs old	☐*Yes* ☐ *No*		__/__/_
Moderna	____/_____/_____	☐ *First Dose* ☐ *Second Dose*	0.5mL ≥ 18 yrs old	☐ *Yes* ☐ *No*		____/____
J & J (Jassen)	____/_____/____	☐ *Single Dose*	0.5mL ≥ 18 yrs	☐ *Yes* ☐ *No*		____/____

Site of IM injection: ☐ RDT ☐ LDT *or* _____________

☐ Anderson, Ann RN
☐ deBroekert, Martha RN
☐ Davila, Michelle, NP
☐ Dutton, Becky RN
☐ Galbraith-Bain, Deanne MOA
☐ Feldman, Cindi RN
☐ Freeman, Ryan, EMT
☐ Kehl, Jennifer RN
☐ Knowlton, Karen RN
☐ Marks, Carla RN
☐ Micheel, Shannon RN
☐ Michels, Deb RN
☐ Royer, Adrienne RN
☐ Sahara, Mary Joy RN
☐ Spear, Sheila RN
☐ Stamps, Cindy MOA
☐ Vait, Rita RN

______________________________________ ________ ____________
Signature and Title of Vaccine Admin. **Date** **Time**

Vaccinator Comments: ____

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