COVID-19 Immunization Consent Form

Name: _____ DOB:_____ Age:_____ Gender:_____

Race/Ethnicity:_____ Phone: _____

Address:_____City:_____Zip:_____

Emergency Name and Phone# : _____ Medicare #:_____

Insurance: Rx Bin_____ Rx PCN: _____ Rx Grp: _____
Person code: _____ Member ID: _____

❑ Check if No Insurance: Driver License #:_____ Social Security #:_____

Please read and check your answer to the following questions:

___Y ___N Are you feeling sick today?
___Y ___N Have you ever received a dose of COVID-19 vaccine? If yes, which: _____
___Y ___N Have you ever had an allergic reaction to a component of the COVID-19 vaccine, including polyethylene glycol (PEG) which is in some medications, such as laxatives and preparations for colonoscopy procedures?
___Y ___N Have you ever had an allergic reaction to Polysorbate?
___Y ___N Have you ever had an allergic reaction to a previous dose of COVID-19 Vaccine?
___Y ___N Have you ever had an allergic reaction to another vaccine (other than COVID-19 Vaccine) or an Injectable medication?
___Y ___N Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication. Including food, pet, environmental, or oral medication allergies
___Y ___N Have you received any vaccine in the last 14 days?
___Y ___N Have you ever had a positive test for or has a doctor ever told you that you had COVID-19?
___Y ___N Have you ever received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?
___Y ___N Do you have a weakened immune system caused by something such as HIV infection or cancer or Do you take immunosuppressive drugs or therapies?
___Y ___N Do you have a bleeding disorder or are you taking a blood thinner
___Y ___N Are you pregnant or breastfeeding?

I certify that I have read this form, that I fully understand the authorizations, acknowledgments, consents, and waivers given above that I was given ample opportunity to ask questions and that any questions have been answered satisfactorily. The signature below indicates my request and consent for the vaccination.

Signature:_____ Date: _____

Office Use Only

Vaccine	Dose	Route	Date Admin	Manufacturer	Lot Number	Expire Date
COVID-19	❑ 1st Dose ❑ 2nd Dose	❑ IM - L Arm ❑ IM- R Arm		❑ Moderna 0.5ml		

Administered by: _____ Date: _____