COVID-19 VACCINE IMMUNIZATION CONSENT FORM

Person Receiving Vaccine:

(Legal) First Name: _____ MI: ____ Last Name: _____

Date of Birth: ☐☐ ☐☐ ☐☐☐☐

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

If you answer "YES" you may not be able to receive the COVID-19 vaccine.

*Section 1: *If YES and further guidance is needed, refer to Pfizer website at www.PfizerMedInfo.com or call 1-800-438-1985 for vaccine information on vaccine temperature excursions, efficacy, safety, stability, dosage, vaccine ingredients, mechanism of action and administration. For overview for Vaccination Providers about Moderna COVID-19 vaccine refer to www.modernatx.com or call 1-866-MODERNA.*	***YES**	**NO**
Have you had a previous COVID-19 vaccine? If yes, date?		
Have you had any vaccines within the previous 14 days? Pfizer-BioNTech COVID-19 vaccine should be administered alone with minimal interval of 14 days before or after any other vaccine.		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?		
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.		
Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive COVID-19 vaccine, a discussion with your healthcare provider can help make informed decision.		
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? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated.		
Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Vaccination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune responses.		

- **NOTE:** Depending on vaccine type, a second dose of COVID-19 vaccine **is** due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. 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 to view current EUA: 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.**

My signature below indicates I have read, understand and agree to section 2. Release and Assignment of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).

Signature of Patient/Parent/Guardian: _____Date_____

PATIENT INFORMATION:

(Legal) First Name: _____ MI: ____ Last Name: _____

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Gender:** ☐Male ☐Female **Phone #: _____**

Street Address: _____ P.O. Box _____ Apt. No. _____

City: _____ State: _____ Zip Code: ☐☐☐☐☐

Race: ☐White ☐Hispanic/Latino ☐Black/African American

☐Native American /Alaska Native ☐Asian ☐Native Hawaiian/Other Pacific Islander ☐Other _____

INSURANCE INFORMATION

INSURANCE STATUS *(Check the following box if you do not have active insurance coverage)*: ☐**UNINSURED**

If uninsured, please provide the following information required for billing to the Department of Health and Human Services:

State Issued ID Number: ☐☐☐☐☐☐☐☐☐☐

Social Security Number: ☐☐☐☐☐☐☐☐☐

Patient's Relationship to Insurance Policy Holder: ☐**Self** ☐**Spouse** ☐**Child** ☐**Other _____**

☐**Medicaid/ARKids Number:** ☐☐☐☐☐☐☐☐☐☐☐☐

☐**Medicare Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐**Insurance Company Name**: _____

Member ID/Policy #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

REQUIRED POLICY HOLDER INFORMATION:

(Legal) First Name: _____ MI: ____ Last Name: _____

Policy Holder Date of Birth: ☐☐ ☐☐ ☐☐☐☐ **dress: _____**

Policy Holder's Employer Name: _____

COVID-19 VACCINE ADMINISTRATION (Completed by staff only)

Refer to product-specific Emergency Use Authorization (EUA) fact sheet for COVID-19 providers

Ultra-cold COVID-19 Vaccine ☐Pfizer-BioNTech		**Frozen COVID-19 Vaccine** ☐Moderna		**Refrigerated COVID-19 Vaccine** ☐AstraZeneca ☐Janssen ☐Novavax-Matrix-M1 ☐Other COVID-19 Vaccine _____
Route	**Site Code**	**Dose Code**	**MFG Code**	**Lot Number**
☐**IM**				

MFG Codes: PFR=Pfizer, MOD=Moderna, ASZ=AstraZeneca, JSN=Janssen, NVX=Novavax, MSD=Merck
Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA
Dose Codes: 1 = First Dose, 2 = Second Dose

Signature and Title of Vaccine Administrator: _____

Date Vaccine Administered: _____/_____/_____

For COVID-19 Provider use only Clinic Name/Code: _____
Location type:(clinic, health department, pharmacy, etc.,) _____

Address: _____City:_____ County: _____

State:_____ Zip Code: _____ Date of Service:_____