

COVID-19 VACCINE CONSENT FORM

Information about person to receive vaccine (please print)

Name: _____ Birth date: ___/___/___ Age: _____ Sex: Male Female

Race: Asian Black Native American Pacific Islander White Other Ethnicity: Hispanic Non-Hispanic

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Do you have insurance? No Yes

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

Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.

Has the person to be vaccinated ever received a COVID-19 vaccine? No Yes

If yes, date: _____ Type/Brand of COVID vaccine: _____

Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex? No Yes

List all allergies: _____

Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy? No Yes

Is the person to be vaccinated sick today? No Yes

Is the person to be vaccinated at least 18 years old? No Yes

If no, is the person to be vaccinated at least 16 years old? No Yes

Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner? No Yes

Has the person to be vaccinated received any other vaccines in the past 14 days? No Yes

Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19? 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). I have received and read the Wyoming Department of Health Notice of Privacy Practices and have had a chance to ask questions about how my information will be used.

I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

Print Parent/Guardian name, if different from client: _____

Client/Parent/Guardian Signature: _____ Date: _____

FOR CLINIC USE ONLY

Clinic site: _____ EUA Fact Sheet Provided: Yes No

Date vaccine administered: ___/___/___ Date booster required: ___/___/___

Vaccine manufacturer: _____ Lot number: _____

Site of IM injection: RDT or LDT or _____ Dose: 0.3ml 0.5ml

Signature and title of vaccine administrator: _____

Nurse's Comments: _____

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INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Insurance: _____
Subscriber's Name: _____ Date of birth: _____
Group No: _____
Policy No: _____
Client's relationship to subscriber: _____

Secondary Insurance: _____
Subscriber's Name: _____ Date of birth: _____
Group No: _____
Policy No: _____
Client's relationship to subscriber: _____

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 authorize my insurance benefits be paid directly to _____ County Public Health.

Client Signature _____ Date _____