COVID Vaccine Informed Consent

Section 1 – Patient Information

First Name:_____ Last Name: _____M.I:_____Gender: M ☐ F ☐

DOB:_____ Age:_____ Mother's Maiden Name: _____

Phone:_____ Email:_____.

Home Address:_____City:_____State:_____ Zip code: _____.
Race: White☐ Asian☐ Black☐ Pacific Islander☐ Native American ☐ Other ☐ Hispanic/Latino?: Y ☐ N ☐

Section 2 – Screening Questions Y=Yes, N=No

1. Do you feel sick today with moderate to severe symptoms? Y ☐ N ☐
2. Do you have a fever? Y ☐ N ☐
3. Have you ever received a dose of COVID-19 vaccine? Y ☐ N ☐
4. Have you received another vaccine (any type) within the past 14 days? Y ☐ N ☐
5. Do you have a severe bleeding disorder? Y ☐ N ☐
6. Have you had a serious allergic reaction (such as anaphylaxis) to any component of a Covid-19 vaccine? Y ☐ N ☐
7. Have you received monoclonal antibodies or convalescent serum in the last 90 days? Y ☐ N ☐
8. Have you ever had a severe allergic reaction (such as anaphylaxis)? Y ☐ N ☐
9. Are you immunocompromised? Y ☐ N ☐
10. **For women:** Are you pregnant or considering becoming pregnant within a month? Y ☐ N ☐
11. Are you breastfeeding? Y ☐ N ☐

Section 3 – Health Insurance Do you have health insurance? Y ☐ N ☐

Insurance Co. Name:_____ ID Number:_____

Subscriber's Name _____Subscriber's Birth Date: _____

Section 4 – Consent for Treatment and Privacy Notice

I certify that the information I have provided is true and accurate. I have had a chance to review the Covid-19 vaccine Information (EUA Fact Sheet) and consent to receive the vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine. I understand and agree that information related to my vaccine administration may be recorded in the Utah Statewide Immunization Information System (USIIS). I hereby release Family Healthcare, and its employees, from all claims arising from such immunizations. We are required to inform you of our privacy practices for the information we collect and keep about you. I have been given a copy of Family Healthcare Notice of Privacy Practices and have had an opportunity to ask questions about how my information may be used.

Signature:_____ Date: _____

Relationship to Client: Self ☐ Parent ☐ Legal Guardian ☐ Other ☐ _____

Section 5 – Family Healthcare Staff Use Only **Patient Account # _____**

Date	Manufacturer	Lot Number	Expiration	Dose	Route	Site	Vaccinator
	Moderna			**0.5mL**	**IM**	☐ **Right Deltoid** ☐ **Left Deltoid**	