

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 Medicare or Medicaid? No Yes--Number: _____

Do you have insurance? No Yes Company: _____ Policy/ID#: _____

Please list policyholder name, date of birth & address, if not you: _____

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(s): _____ Type/Brand of COVID vaccine: _____

If yes, and if the initial vaccination series is complete, is the person seeking a **booster** dose? No Yes
(Recommended for all individuals 16 years and older, 6 mo. after the initial series for mRNA, 2 mo. after J&J)

Does the person attest to having a qualifying moderate/severe immunocompromising condition? No Yes
(e.g. cancer treatment, organ transplant, etc.) (Only applies to individuals 12 years and older.)
If yes, it is recommended to receive an additional, full dose, at least 28 days after initial series completion.

Please indicate the age of the person to be vaccinated: 18 years or older
 12-17 years old
 5-11 years old

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

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

Does the person to be vaccinated have a history of myocarditis or pericarditis? No Yes

Has the person to be vaccinated received passive antibody therapy as a treatment for COVID-19? No Yes

I have read, or have had explained to me, the Vaccine Information Statement (VIS,) or 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. 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.

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

X Client/Parent Signature: _____ Date: _____

Print name if guardian or parent: _____

Clinic site: _____ Date of vaccine: _____ Date 2nd dose due: _____ JJ M-Full M-B Pf-Full Pf-Ped

VIS/EUA Fact Sheet Provided: Yes No Pfizer 0.2ml Pfizer 0.3ml Moderna 0.5ml Moderna 0.25ml J&J 0.5ml

Site of IM injection: RDT or LDT or _____ Lot number: _____

Signature & title of vaccine administrator: _____

Comments: _____ Billed WYIR