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? (Recommended for all individuals 16 years and older, 6 mo. after the initial series for mRNA, 2 mo. after J&J)	☐ No ☐Yes
Does the person attest to having a qualifying moderate/severe immunocompromising condition? (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.	☐ No ☐Yes
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? List all allergies: _____	☐ No ☐Yes
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☐

COVID-19 VACCINE CONSENT FORM

Screening Questionnaire & Consent for Influenza Vaccine:

1. Have you received flu vaccine before? ____No ____Yes
2. Did you have any problems with previous flu vaccine? ____No ____Yes
3. Are you ill today? ____No ____Yes
4. Do you have allergies to eggs, latex or to Thimerosal Mercury (a medication preservative)? ____No ____Yes
5. Do you have a history of Guillian-Barre Syndrome (a paralysis problem)? ____No ____Yes
6. If you are younger than 9 years of age, have you received flu vaccine before? ____No ____Yes
7. Have you received a pneumonia vaccine? ___ No ___ Yes If yes, what year? PPSV23 _____ PCV13_____

I have read, or have had explained to me, the Vaccine Information Statement (VIS) about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza 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). If qualified, I authorize billing to my insurance company or my employer. 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.

✖ **Client/Parent/Guardian Signature**: _____Date: _____

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

Influenza Dosage Schedule:

Age Group	Dosage Schedule
9 Years and older	**0.5ML: One dose**
6 Months – 8 Years	**0.5 ML: One dose*†**

** For children younger than 9 years of age, refer to the 2021 ACIP Recommendations to determine the need for one or two doses. If two doses are needed, separate the doses by at least 4 weeks.*

†Dosage for age may vary by brand of vaccine. See package insert.

CLINIC SITE: _____ VIS DATE: 8/6/2021

DATE VACCINE ADMINISTERED: _____ BOOSTER REQUIRED? NO YES --DATE: _____

VACCINE MANUFACTURER & LOT NUMBER: _____ (FLUZONE) IIV4 RIV4 IFLUBLOK)

SITE OF IM INJECTION: RDT OR LDT RLT OR LLT DOSE: 0.5ML

SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR: _____ FORM REVIEWED BY:_____

NURSE'S COMMENTS: _____

Billed☐ WYIR☐