Hancock Public Health COVID-19 Vaccine Consent Form -Boosters

SECTION: 1 PATIENT INFORMATION

First Name: _____ Middle Initial _____ Last Name: _____

Date of Birth: _____ Male/Female: ____ Age: ____ Phone number: _____

Street Address: _____ City: _____

State: _____ Zip code: _____ County of Residence: _____

SECTION 5: PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE
Policy holder_____
Policyholder date of birth_____
Social Security #_____
Relationship to patient_____

SECONDARY INSURANCE
Policy holder_____
Policy holder date of birth_____
Social Security #_____
Relationship to patient_____

SECTION 2: SCREENING QUESTIONS

1. Have you completed a COVID-19 vaccine primary series? ☐ Yes ☐ No
2. Has it been at least 2 months since your last COVID-19 vaccine shot? ☐ Yes ☐ No

Please answer the health questions below:	Yes	No	Unknown
1. Have you ever had a severe allergic reaction to a vaccine or any injection in the past?			
2. Have you ever tested positive for COVID-19 or had a doctor tell you that you had COVID-19?			
3. Have you been identified as a case of COVID-19 in the last 2 weeks?			
4. Have you received antibody therapy for COVID-19 in the last 3 months?			
5. Do you have any serious health conditions?			
6. Do you have a weakened immune system or are you on immunosuppressive drugs?			
7. Do you have a bleeding disorder or are you taking a blood thinner?			
8. Are you pregnant or breastfeeding?			
9. Do you feel sick today?			

SECTION 3: ELIGIBILITY AND CONSENT

Please visit the CDC website cdc.gov/coronavirus/2019-ncov/vaccines/index.html to learn about the benefits and risks (VIS) of the COVID-19 vaccine. Please visit our website (posted at the clinic) to read our Privacy Policy.

PLEASE INITIAL THE BOX BELOW

☐ By signing below, you agree that 1) you reviewed both the VIS/Fact Sheet and Privacy Policy, and have had the chance to ask questions that were answered to my satisfaction 2) you understand the benefits and risks of the vaccine and you are asking th at the vaccine be given to you or the person named on this form for whom you are authorized to make this request, 3) you hereby cons ent that we can bill your insurance, if applicable, 4) you authorize the release of this vaccination record and all information on this form to your state's Immunization Program and the CDC, and 5) we can release this record to your doctor, school, or employer if requested. If the person who is being vaccinated is age 17 or under, by signing below you agree that you are authorized to consent to the vaccination of the patient and the patient on this form may receive vaccine with or without you, as the parent or guardian, present at the time of vaccination. After receiving your vaccine, we recommend you wait at least 15 minutes. If you leave the vaccination site before 15 minutes has passed after your vaccination you assume any risks associated with not waiting the recommended amount of time.

SECTION 4: SIGNATURE

Signature of Patient or guardian: _____
Name of patient or guardian (print): _____
Relationship to Patient: _____ Date: _____

SECTION 6: VACCINATION RECORD

Date	Manf. /Lot	Dose	Route	Site	Nurse Signature
			IM		