COVID-19 VACCINE CONSENT FORM

Clinic Use:
J&J Mod. Pf 12+ Pf 5-11
Dose: 1 2 3 4 5 Full Half

Please complete form with information about the person who is receiving the vaccine (please print)

Name: ______________________ **Birth Date**: __________ **Age**: ______ **Sex**: ☐ Male ☐ Female

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

Mailing 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.

How many doses of a COVID-19 vaccine have you received? ☐0 doses ☐1 dose ☐2 doses ☐3 doses ☐4 doses Date of dose 1:__________ Date of dose 2:__________ Date of dose 3:__________ Date of dose 4:__________ Type of dose 1:__________ Type of dose 2:__________ Type of dose 3:__________ Type of dose 4:__________	
How old are you?	☐ 18 years or older ☐ 12-17 years old ☐ 5-11 years old
Do you have a moderate/severe immunocompromising condition? (for example, cancer treatment, organ transplant, etc.)	☐ No ☐Yes
Do you have an allergy to any medications, food, vaccine, or latex? List all allergies: ______________________________	☐ No ☐Yes
Have you ever had a severe reaction to any vaccine or injectable therapy?	☐ No ☐Yes
Are you sick today?	☐ No ☐Yes
Do you have a bleeding disorder or are you taking a blood thinner?	☐ No ☐Yes
Do you have a history of myocarditis or pericarditis?	☐ 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/Guardian Signature: ________________________________ Date: ____________

Client/Parent/Guardian Name (printed): ________________________________

Clinic site: ____________ ***Date of vaccine:*** ____________ ***Date next dose due:*** ______________

Dose: ☐Pfizer 3mcg/0.2ml (under 5 years) ☐Pfizer 10mcg/0.2ml (5-11 years) ☐Pfizer 30mcg/0.3ml (12 +years)

☐Moderna 50mcg/0.25ml (18+years) ☐Moderna 100mcg/0.5ml (18+years) ☐J&J 0.5ml (18+years)

Site of IM injection: ☐RDT ☐LDT ☐RLT ☐LLT ***VIS/EUA Fact Sheet Provided:*** *Yes No* ***Lot number:*** ______________

Signature & title of vaccine administrator: ________________________________

Billed WYIR

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Comments: