Covid-19 Vaccination Consent Form

Last Name____________________________________First Name___________________________Middle Int.__

Address____ City_______________ State____Zip________

Email
Address____

Date of Birth_____________________ SS#______________________________________Sex M____ F____

Phone_____________________________________ Race:________________ Phase:________________

I have read the Fact Sheet for Recipients and Caregivers Vaccine Information Statement about the Moderna Covid-19 Vaccine. I have had a chance to ask questions to my satisfaction. I understand the benefits and risks of the Covid-19 Vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to make the request. I agree to stay in the general area for fifteen (15-30) minutes after receiving my vaccination. I authorize the release of any medical information or other information necessary to process an insurance claim.

Medicare ID #____

Medicare Part D ID#____

Commercial Insurance Plan___________________________ ID #___________________________________

Please, sign and date the day of the clinic ONLY

*SIGNATURE____*DATE__________________________

*SIGNATURE OF PARENT OR GUARDIAN (if patient under the age of 18)___________________________

Injection Site: R___ L___ Deltoid IM Manufacturer: Moderna Covid-19 Vaccine

Lot # _________________ Expiration Date: ______________________________

Vaccine Administrator__________________________________Date Administered____________