Covid-19 Vaccination Consent Form

ANY CHANGES OF PERSONAL INFORMATION SINCE THE 1ST DOSE OF VACCINATION?

YES NO
(CIRCLE ONE)
If No Skip to Signature Section of Form
If Yes Complete all sections below

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_____