DATE _____ TIME _____

COVID-19 VACCINE IMMUNIZATION CONSENT FORM

COKER HAMPTON WELLNESS CENTER

Person Receiving Vaccine:

(Legal) First Name: _____ MI: ____ Last Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____

MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. If you answer "YES" you may not be able to receive the COVID-19 vaccine.

	CIRCLE ONE
1. Have you had a previous COVID-19 vaccine? If yes, date?	YES NO
2.Have you had any vaccines within the previous 14 days? Moderna COVID-19 vaccine should be admistered alone with minimal interval of 14 days before or after any other vaccine.	YES NO
3. Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?	YES NO
4. Have you ever had severe allergic reaction (anaphlactic reaction) to ay vaccine, vaccine component or injectable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness.	YES NO
5. Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive COVID-19 vaccine, a discussion with your healthcare provider can help make informed decision.	YES NO
6. Are you immunocompromised of have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obesity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated.	YES NO
7. Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Vaccination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune responses.	YES NO

NOTE: This vaccine type requires a second dose of COVID-19 vaccine, due 28 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date.

RELEASE AND ASSIGNMENT:

- I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for each vaccine visit the website www.cvdvaccine.com to view current EUA: or you may also visit the Local Health Unit or private provider to receive a printed copy of the EUA Fact Sheet.
- I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine.
- I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice.
- I understand that information about this COVID-19 vaccination will be included in (WebIZ) Arkansas Immunization Information System.

To My Insurance Carrier(s):

- I authorize the release of any medical information necessary to process my insurance claim(s).
- I authorize and request payment of medical benefits directly to this COVID-19 Provider.
- I agree that the authorization will cover all medical services rendered until I revoke the authorization.
- I agree that the photocopy of this form may be used instead of the original.

My signature below indicates I have read, understand and agree to section **2. Release and Assignment** of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).

Signature of Patient/Parent/Guardian:

_____Date_____

COVID-19 VACCINE ADMINISTRATION (Completed by staff only)

Refer to product-specific Emergency Use Authorization (EUA) fact sheet for COVID-19 providers

Ultra-cold COVID-19 Vaccine Pfizer-BioNTech		**Frozen COVID-19 Vaccine** Moderna		**Refrigerated COVID-19 Vaccine** AstraZeneca Janssen Novavax-Matrix-M1 Other COVID-19 Vaccine _____
Route	**Site Code**	**Dosage mL**	**MFG Code**	**Lot Number**
IM				

MFG Codes: PFR=Pfizer, MOD=Moderna, ASZ=AstraZeneca, JSN=Janssen, NVX=Novavax, MSD=Merck
Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

Signature and Title of Vaccine Administrator: _____

Date Vaccine Administered: _____/_____/_____