COVID-19 VACCINE CONSENT FORM – PLEASE FILL OUT COMPLETELY

GIBSONS PHARMACY & COMPOUNDING

240 E Winchester, Murray, UT 84107
(P): 801-262-5526
gibsonspharm@gmail.com

Name: _____ **Birth date**: ___/___/_____ **Age**: _____ **Sex**: ☐ Male ☐ Female

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

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Phone: _____ **Do you have insurance?** ☐ No ☐ Yes

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.

Are you feeling sick today?	☐ No ☐Yes
Have you ever received a dose of COVID-19 vaccine? *If yes, date: _____ Brand of COVID vaccine: ☐ Moderna ☐ Pfizer*	☐ No ☐Yes
Do you have any allergies to any medications, food, vaccine, or latex? *List all allergies: _____*	☐ No ☐Yes
Have you ever had an allergic reaction to any vaccine or injectable therapy?	☐ No ☐Yes
Have you received ANY vaccine in the last 14 days?	☐ No ☐Yes
Have you ever had a positive test for COVID-19, or has a doctor ever told you that you had COVID-19?	☐ No ☐Yes
Have you received passive antibody therapy as treatment for COVID-19?	☐ No ☐Yes
Do you have a bleeding disorder or are you taking a blood thinner?	☐ No ☐Yes
Do you have a weakened immune system caused by something such as HIV, cancer, or do you take immunosuppressive drugs or therapies (*ie., steroids*)?	☐ No ☐Yes
Are you pregnant or breastfeeding?	☐ No ☐ Yes

I have read, or have had explained to me, 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 BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

Print Client/Parent/Guardian name: _____

Client/Parent/Guardian Signature: _____Date: _____

_____**FOR CLINIC USE ONLY**_____

Date vaccine administered: ____/____/_____ ***Date booster required***: ____/_____/_____

Vaccine manufacturer: _____ ***Lot number***: _____

Site of IM injection: *RDT or LDT* ***Dose***: *0.3ml 0.5ml*

Signature and title of vaccine administrator: _____