

Vaccine Consent Form

Patient Name: _____ Dob: ____ / ____ / ____ Age: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

- I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named below, a minor for whom I represent that I am authorized to sign this Consent Form.
- I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine
- I understand that I will be receiving the vaccination at no cost to me.
- If insured, I will provide my medical insurance cards at my vaccine appointment. I authorize the pharmacy to bill my insurance on my behalf for the immunization administration - understanding I will not incur any costs.

If uninsured, you must check the box below to attest that the following information is true and accurate:

- I do not have any insurance, including but not limited to, Medicare, Medicaid, or any other private or government-funded benefit plan.
- DL# _____ or SSN# _____ (only if uninsured)

Signature of Vaccine Recipient & EUA /VIS (or *Signature of Parent/Guardian if Patient is < 18 years old*):

_____ Date: _____

Route

- Deltoid (L / R) - Use $\frac{5}{8}$ -1" 25G Needle (PREFERRED ROUTE FOR AGES 3 YO+ PER ACIP)

Vaccine

- Pfizer 30mcg (GREY TOP-Bivalent-12+) Dose # _____
if Mix & Match, previous dose was: _____
- Pfizer 10mcg (ORANGE TOP-5-11 year old) Dose # _____
- Pfizer (BURGUNDY TOP-6 months to 5 years) 0.2ml Dose # _____
- Moderna (BLUE TOP-Bivalent) 0.25ml or 0.5ml (circle) Dose # _____ *if Mix & Match, previous dose was: _____.*
- Moderna (BLUE TOP-6 months through 5 years) 0.25ml Dose # _____
- J&J Dose _____ *if Mix & Match, previous dose was: _____*

Signature of Vaccinator: _____ Date: _____