Covid-19 Vaccine Information and Consent

Last Name	First Name	MI	Date of Birth	☐ Male ☐ Female

Address	City	State	Zip

Phone/Best Contact Number	Email	Primary Care Provider	Emergency Contact	Emergency Contact #

Race: (check only 1)
☐ Asian/Polynesian ☐ Black ☐ Multiracial
☐ Native Am/Alaskan ☐ White ☐ Unknown

Ethnicity: (check only 1)
☐ Not Hispanic
☐ Hispanic ☐ Unknown

Primary Language
☐ English
☐ Other

Insurance Company

Please answer the health questions below:	Yes	No	Do Not Know	Anything Changed?
1. Are you sick today or currently in an isolation or quarantine period for COVID-19?	☐	☐	☐	
2. Have you tested positive for COVID-19 in the last 10 days?	☐	☐	☐	
3. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 in the past 90 days?	☐	☐	☐	
4. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something: For example, a reaction for which you were treated with Epinephrine or EpiPen, or for which you had to go to the hospital?	☐	☐	☐	
5. Have you ever had a serious reaction after receiving a vaccine or another injectable medication?	☐	☐	☐	
6. Have you received any vaccinations in the past 14 days or are scheduled to receive any vaccine in the next 14 days?	☐	☐	☐	
7. Do you have a bleeding disorder or are you taking a blood thinner? If so, which medication _____	☐	☐	☐	
8. Do you currently have a weakened immune system, take immunosuppressive medications, or receive radiation or chemotherapy treatment?	☐	☐	☐	
9. Are you pregnant or currently breastfeeding?	☐	☐	☐	
10. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐	
*If yes, which vaccine product and the date administered: ☐ Pfizer ☐ Moderna ☐ Janssen Date received:				
Staff verification of any changes since form completion until day of vaccination *(initial in box to right)*				

- I have been given a copy and have read, or have had explained to me, the information in the **FACT SHEET** for the COVID-19 vaccine. I understand the FDA has authorized emergency use of the Moderna COVID-19 vaccine, which is not an FDA-approved vaccine. I have had the chance to ask questions that were answered to my satisfaction.
- **I understand the COVID-19 vaccine may require a second dose 3-4 weeks apart** *(depending on the vaccine manufacturer)*. If this is my first dose of the Pfizer or Moderna COVID-19 vaccine, I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the FACT SHEET to complete the vaccination series.
- **My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine. Those with a history of previous anaphylactic reactions, should stay on site for 30 minutes.** I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician.
- An administration fee may be billed to third party payers. I authorize Rice Medical Associates to bill any and all third party payers for this service. I authorize the release of any medical or other information necessary to process this claim.
- I understand the significant known and potential risks and benefits of the COVID-19 vaccine as explained in the FACT SHEET and that some potential risks and benefits may remain unknown. **I REQUEST THE COVID-19 VACCINE BE GIVEN TO ME OR THE PERSON LISTED**

Date	Print Name	Patient or Parent/Guardian Signature

FOR ADMINISTRATIVE USE ONLY

Vaccine	Dose (0.5ml)	Route/Site (IM/Deltoid)	Date Doses Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	☐ 1st Dose	☐ L ☐ R		☐ Janssen			
	☐ 2nd Dose	☐ L ☐ R		☐ Moderna			