PFIZER-RIONTECH COVID-19 VACCINE IMMUNIZATION CONSENT FORM

| Legal) First Name: Date of Birth: MI: Last Name: Date of Birth: MI: Last Name: Date of Birth: Last Name: La | GU : N. (G. 1 | VIII COLLEGE C | | | | |
|--|---|--|----------|-----|--|--|
| Person Receiving Vaccine: Legal) First Name: MI: Last Name: Last Name: Last Name: Last Name: Last Old Pirit Name: Last Old Pirit Name: Last Name: Last Name: Last Name: Last Name: Last Name: Last Old Pirit Name: Last Name: | For COVID-19 Provider use only Clinic Name/Code: | | | | | |
| Person Receiving Vaccine: Legal) First Name: MI: Last Name: Date of Birth: | Location type:(clinic, health department, pharmacy, etc.,) | Country | | | | |
| Person Receiving Vaccine: Legal) First Name: MI: Last Name: Date of Birth: | State: Zin Code: Date of S | Service: | | | | |
| Legal) First Name: Date of Birth: | StateZip code Date of t | 5CI VICC. | | | | |
| Legal) First Name: Date of Birth: | | | | | | |
| 1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. If yes and further guidance is needed. Refer to Pfizer website at www.PfizerMedInfo.com or call 1-800-438-1985 for vaccine information on vaccine temperature excursions, efficacy, safety, attability, dosage, vaccine ingredients, mechanism of action and administration and admini | Person Receiving Vaccine: | | | | | |
| 1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. 1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. 1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. 1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. 1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. 1. MEDICAL HISTORY: Vaccine information on vaccine temperature excursions. efficacy. safety, was a safety and an administration and administr | (Legal) First Name: | I: Last Name: | | | | |
| 1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine. If YES and further guidance is needed, Refer to Pfizer website at www.PfizerMedInfo.com or call 1-800-438-1985 for vaccine information on vaccine temperature excursions, efficacy, safety, stability, dosage, vaccine ingredients, mechanism of action and administration lave you had a previous COVID-19 vaccine? If yes, date? lave you had any vaccines within the previous 14 days? Pfizer-BioNTech COVID-19 vaccine should be indiministered alone with minimal interval of 14 days before or after any other vaccine. Jo you have a fever today? Are you sick today? Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in solation? Are you currently in quarantine for known exposure to COVID-19? lave you ever had severe allergic reaction (anaphylactic reaction) to any 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. Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive 20VID-19 vaccine, a discussion with your healthcare provider can help make informed decision. Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe besisty, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated. Jave you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Are converted to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your recerved for part least 90 days to avoid interference of treatment with vaccine-induced manune responses. MOTE: Depending on vaccine type, a second dose of COVID-19 vac | | | | | | |
| #YES and further guidance is needed, Refer to Pfizer website at www.PfizerMedInfo.com or call 1-800-438-1985 for vaccine information on vaccine temperature excursions, efficacy, safety; tability, dosage, vaccine ingredients, mechanism of action and administration Have you had a previous COVID-19 vaccine? If yes, date? Have you had any vaccines within the previous 14 days? Pfizer-BioNTech COVID-19 vaccine should be indiministered alone with minimal interval of 14 days before or after any other vaccine. Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in solation? Are you currently in quarantine for known exposure to COVID-19? Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or nigetable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness. Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive ZOVID-19 vaccine, a discussion with your healthcare provider can help make informed decision. Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe besity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated. Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Accination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced minune responses. NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. Please read the section on the reverse side of | Date of Birtin. | | | | | |
| #YES and further guidance is needed, Refer to Pfizer website at www.PfizerMedInfo.com or call 1-800-438-1985 for vaccine information on vaccine temperature excursions, efficacy, safety; tability, dosage, vaccine ingredients, mechanism of action and administration Have you had a previous COVID-19 vaccine? If yes, date? Have you had any vaccines within the previous 14 days? Pfizer-BioNTech COVID-19 vaccine should be indiministered alone with minimal interval of 14 days before or after any other vaccine. Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in solation? Are you currently in quarantine for known exposure to COVID-19? Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or nigetable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness. Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive ZOVID-19 vaccine, a discussion with your healthcare provider can help make informed decision. Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe besity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated. Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Accination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced minune responses. NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. Please read the section on the reverse side of | | | | | | |
| #YES and further guidance is needed, Refer to Pfizer website at www.PfizerMedInfo.com or call 1-800-438-1985 for vaccine information on vaccine temperature excursions, efficacy, safety; tability, dosage, vaccine ingredients, mechanism of action and administration lave you had a previous COVID-19 vaccine? If yes, date? Have you had any vaccines within the previous 14 days? Pfizer-BioNTech COVID-19 vaccine should be indiministered alone with minimal interval of 14 days before or after any other vaccine. Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in solation? Are you currently in quarantine for known exposure to COVID-19? Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or njectable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness. The 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. The you immunocompromised or 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. Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Accination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced minune responses. NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. Please read the section on the reverse side of | 1. MEDICAL HISTORY: Complete the following questi | ons for the individual receiving the | vaccine. | | | |
| Ave you recall edition of the provider of a discussion with your healthcare provider can help make informed decision. Ave you received monoclonal antibodies or convalescent plasma as part of COVID-19 tractiment with vaccine-induced munice responses. NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccine date. | | | | | | |
| Have you had a previous COVID-19 vaccine? If yes, date? Have you had any vaccines within the previous 14 days? Pfizer-BioNTech COVID-19 vaccine should be indiministered alone with minimal interval of 14 days before or after any other vaccine. Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in solation? Are you currently in quarantine for known exposure to COVID-19: Have you ever had severe allergic reaction (nanphylactic reaction) to any vaccine, vaccine component or nijectable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness. 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. Are you immunocompromised or 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 ndividuals may still receive COVID-19 vaccine unless otherwise contraindicated. Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Accination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced munure responses. NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. **RELEASE AND ASSIGNMENT.** Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. **My signature below indicates I have read, understand and agree to section 2. Release and Assignment of t | *If YES and further guidance is needed, Refer to Pfizer websi | te at www.PfizerMedInfo.com or call | | | | |
| Have you had a previous COVID-19 vaccine? If yes, date? Have you had any vaccines within the previous 14 days? Pfizer-BioNTech COVID-19 vaccine should be ideministered alone with minimal interval of 14 days before or after any other vaccine. Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in solation? Are you currently in quarantine for known exposure to COVID-19? Have you ever had severe allergic reaction (anaphylactic reaction) to any 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. 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. Are you immunocompromised or 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. 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 minune responses. NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. Signature of Patient/Parent/Guardian: Please ign here | | | *YES | NO | | |
| Have you had any vaccines within the previous 14 days? Pfizer-BioNTech COVID-19 vaccine should be idministered alone with minimal interval of 14 days before or after any other vaccine. Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in solation? Are you currently in quarantine for known exposure to COVID-19? Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or njectable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness. Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive 20VID-19 vaccine, a discussion with your healthcare provider can help make informed decision. Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obseivt, do you smoke or have diabetes mellitars? Are you receiving any immunosuppressive therapy? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated. Fave you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Accination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced mmune responses. NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. Please sign here Please sign here | stability, dosage, vaccine ingredients, mechanism of action a | nd administration | 122 | 1,0 | | |
| deministered alone with minimal interval of 14 days before or after any other vaccine. Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in solation? Are you currently in quarantine for known exposure to COVID-19? Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or nicetable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness. 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. Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obseivity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated. 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 mmune responses. NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. Wy 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: | Have you had a previous COVID-19 vaccine? If yes, date? | | | | | |
| deministered alone with minimal interval of 14 days before or after any other vaccine. Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in solation? Are you currently in quarantine for known exposure to COVID-19? Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or nicetable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness. 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. Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obseive, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated. 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 mmune responses. NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. Please sign here Please sign here Please sign here | * * | NTech COVID-19 vaccine should be | | | | |
| solation? Are you currently in quarantine for known exposure to COVID-19? Have you ever had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or nijectable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness. 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. Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obsestiv, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated. 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 information in the vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. Wy 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: | | | | | | |
| Have you even had severe allergic reaction (anaphylactic reaction) to any vaccine, vaccine component or njectable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness. 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. Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe belowity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive COVID-19 vaccine unless otherwise contraindicated. 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 minute responses. PONOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. Please sign here Please sign here Please sign here Assignment of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA). | | | | | | |
| njectable therapy? Such as difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness. 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. Are you immunocompromised or 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. 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 minune responses. NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. Please sign here 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: | | | | | | |
| Over your body, dizziness and weakness. 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. Are you immunocompromised or 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. Fave you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Fave you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Fave you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Fave you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Fave you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Fave you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Fave you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Fave you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Fave you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Fave you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Fave you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Fave you received monoclonal antibodies or convalescent plasma as part of COVID-19 vaccine in the received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Fave you received monoclonal antibodies or convalescent plasma as part of COVID-19 vaccine in the received monoclonal antibodies or convalescent plasma as part of COVID-19 vaccine in the received monoclonal antibodies or convalescent plasma as part of COVID-19 vaccine in the received monoclonal | | | | | | |
| 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. Are you immunocompromised or 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. 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 minume responses. PNOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. 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: | | ce and throat, fast heartbeat, bad rash all | | | | |
| COVID-19 vaccine, a discussion with your healthcare provider can help make informed decision. Are you immunocompromised or 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. 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 mmune responses. NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. Wy signature below indicates 1 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: | | Women in this group may receive | | | | |
| Are you immunocompromised or 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 ndividuals may still receive COVID-19 vaccine unless otherwise contraindicated. 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 munure responses. NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. 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: | | | | | | |
| besity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These ndividuals may still receive COVID-19 vaccine unless otherwise contraindicated. 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 mmune responses. NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. 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: Please sign here | | | | | | |
| 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 mmune responses. NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. 2. RELEASE AND ASSIGNMENT. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. Please sign here Wy 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: | | | | | | |
| Vaccination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced mmune responses. NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. 2. RELEASE AND ASSIGNMENT. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. Wy 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: | | | | | | |
| NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. 2. RELEASE AND ASSIGNMENT. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. Wy 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: | | | | | | |
| NOTE: Depending on vaccine type, a second dose of COVID-19 vaccine is due in 21 days after initial vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. 2. RELEASE AND ASSIGNMENT. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. Please sign here Wy 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: | • | ence of treatment with vaccine-induced | | | | |
| vaccine. Refer to your COVID-19 vaccination record card for second dose due date. Contact your PCP or your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. 2. RELEASE AND ASSIGNMENT. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. Wy 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: | | 1 . 21 1 . 6 1 | | | | |
| your ADH Local Health Unit in 21 days for more information. Keep your COVID-19 vaccination record card for your records for proof of initial vaccine date. 2. RELEASE AND ASSIGNMENT. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. Wy 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: | | | | | | |
| 2. RELEASE AND ASSIGNMENT. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. Wy 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: | · · · · · · · · · · · · · · · · · · · | · · · · · · · · · · · · · · · · · · · | | | | |
| 2. RELEASE AND ASSIGNMENT. Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. 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: | | sep your covid 19 vaccination record | | | | |
| Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. 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: | | | | | | |
| Please read the section on the reverse side of this form. The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. 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: | 2 DELEACE AND ACCIONMENT | | | | | |
| The Providers Privacy Notice is available at the clinic site or accompanies this form. Then sign in the box at right. Then sign in the box at right. Then sign in the box at right. Please sign here 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: | · · | My signature below indicates I have | read | | | |
| site or accompanies this form. Then sign in the box at right. Assignment of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA). Signature of Patient/Parent/Guardian: | · · · · · · · · · · · · · · · · · · · | | | and | | |
| Then sign in the box at right. Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA). Signature of Patient/Parent/Guardian: | The Florida of Florida is available at the climb | | | | | |
| Signature of Patient/Parent/Guardian: Please sign here | | I = | | | | |
| Please sign here | Then sign in the box at right. | | _ | - | | |
| Please sign here | | | | | | |
| Please sign here | Signature of Patient/Parent/Guardian: | | | | | |
| i i | Please sign here ! | | | | | |
| | → | l Date | | | | |
| | | | | | | |

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.
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.

| PATIENT INF | FORMATION: | | | | | | |
|---|--------------------|---|--------------------|---|--------------|--|--|
| (Legal) First N | lame: | | MI | : Last Name: | | | |
| Date of Birth: / / Gender: Male Female Phone #: | | | | | | | |
| | | | | Apt. No | | | |
| City: | | | State: | Zip Code: | | | |
| | | no Black/African | | | | | |
| | | ta Native Asian appropriate box): | Native Hawaiian | Other Pacific Islander Other | | | |
| Patient's Relat | tionship to Insura | nce Policy Holder: | ☐ Self ☐ Spou | se Child Other | | | |
| ☐ Medicaid N | lumber: | | | | | | |
| ☐ Medicare N | Number: | | | | | | |
| ☐ Insurance (| Company Name: | | | | | | |
| Member ID/Po | olicy #: | | | | | | |
| REQUIRED P | OLICY HOLDE | R INFORMATION | ī : | | | | |
| | | | | Name: | | | |
| Policy Holder | Date of Birth: | / / / | Email | l Address: | | | |
| Policy Holder's Employer Name: | | | | | | | |
| | | ISTRATION (Comp | | y) sheet for COVID-19 providers | | | |
| | • | | | Refrigerated COVID-19 Vacci | ne | | |
| | | Frozen COVID-19 |) Vaccine | AstraZeneca | _ | | |
| | | Moderna | | ☐ Janssen☐ Novavax-Matrix-M1 | | | |
| | | | | Other COVID-19 Vaccine | | | |
| Route | Site Code | Dosage mL | MFG Code | Lot Number | | | |
| ☐ IM | | | | | | | |
| | | rna, ASZ=AstraZeneca, I eltoid = LD. Right Leg = | | ovavax, MSD=Merck ht Arm = RA, Left Arm = LA | | | |
| | | | , Den Deg DD, Rigi | | | | |
| Signature and | Title of Vaccine | Administrator: | | · | | | |
| Date Vaccine A | Administered: | / | / | 1 | 2/14/20 | | |