COVID-19 Vaccination Consent

Name Last: _____ First: _____

Date of Birth (M/D/Y): _____ Sex: M ___ F___ Transgender ___ Self-Identify _____

Email: _____ Cell# _____

Address: _____

City: _____ State: _____ Zip: _____

HEALTH HISTORY:

1. Are you moderately or severely ill today? Yes _____ No _____
2. Do you have allergies to food or medications? Yes _____ No _____
3. Have you ever had a serious reaction after a vaccination or any injectable medication? Yes _____ No _____
4. In the past 14 days have you tested positive for COVID-19? Yes _____ No _____
   a. Had contact with another person with lab confirmed COVID-19? Yes _____ No _____
5. Have you received a monoclonal antibody or convalescent plasma for COVID-19 in the last 90 days? Yes _____ No _____
6. Have you ever had Guillain Barre Syndrome? Yes _____ No _____
7. Have you received a COVID-19 vaccine before? If yes, list date(s) Yes _____ No _____

   _____

COMPLETE IF APPLICABLE:

THIRD PRIMARY SERIES DOSE for individuals 12 years and older who received Pfizer or Moderna as their primary series with moderately to severely compromised immune systems

☐ I request to receive a third COVID-19 vaccine dose today. I attest that it has been at least 28 days since my last Pfizer or Moderna COVID-19 vaccine dose and that I have a qualifying condition as defined by the Centers for Disease Control and Prevention (CDC).

BOOSTER DOSE for any individual 18 years and older who received **Pfizer or Moderna** for their primary series.

☐ I request to receive a booster COVID-19 dose today. I attest that it has been at least 6 months since my last Pfizer or Moderna COVID-19 vaccine dose.

BOOSTER DOSE for any individual 18 years and older who received **Johnson & Johnson/Janssen** for their primary vaccination.

☐ I request to receive a booster COVID-19 dose today. I attest that it has been at least 2 months since my last Johnson & Johnson/Janssen COVID-19 vaccine dose.

If you have insurance – including Medicare, Medicaid or private insurance – we will bill your insurance for administration of the vaccine. ***There will be no cost to you.*** *Insurance is not required to receive the COVID-19 vaccine.*

I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine requested and ask that the vaccine currently due be given to me.

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV-2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the Countermeasures Injury Compensation Program and filing a claim is available by calling 1-855-266-2427 or visiting http:/ / www.hrsa.gov/ cicpj.

Signature: _____ Date: _____