COVID-19 VACCINE CONSENT FORM

cascade HEALTH

Last Name First Name MI Date of Birth Age Gender (at birth)

Address City State Zip Phone#

Race (optional): ☐White ☐Black/African American ☐Hispanic ☐ Asian ☐Am. Indian/Alaska Native ☐Native Hawaiian ☐Other Pacific Islander ☐ I prefer not to answer

Ethnicity (optional): ☐Not of Hispanic/Latino Origin ☐Hispanic/Latino Origin ☐ I prefer not to answer

Employer Name:_____ **Personal Email:**_____

Do you have insurance? ☐ Yes ☐No Primary Insurance Name: _____

ID#_____ Group#: _____

Plan Type: ☐ Commercial ☐ Medicaid ☐ Medicare/Med Advantage, if you have Med Advantage Plan we also need your Medicare ID#_____

Insured Name: ☐ Self_____ DOB:_____ Relationship:_____

The following questions will help determine if there are needed precautions to take while administering your vaccination or help determine if there is any reason you should not receive a COVID immunization injection.

Have you ever received a COVID-19 vaccine?	☐ No ☐ Yes
If yes, date:_____ Type/Brand of COVID vaccine:_____	
Have you ever had a severe allergic reaction (anaphylaxis) to any vaccine or injectable therapy?	☐ No ☐ Yes
Have you ever negatively reacted to having your blood drawn or receiving other injections/ vaccinations?	☐ No ☐ Yes
Are you currently sick today?	☐ No ☐ Yes
Do you have a bleeding disorder or are they taking a blood thinner?	☐ No ☐ Yes
Have you received any other vaccines in the past 14 days?	☐ No ☐ Yes
Have you received passive antibody therapy as treatment for COVID-19?	☐ No ☐ Yes
Have you been diagnosed with COVID-19 infection in the past 90 days?	☐ No ☐ Yes
For women only, are you pregnant or currently 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). The above information is true to the best of my knowledge. If qualified, I authorize billing to my insurance company and release of information required to process my claims.

I HAVE BEEN ADVISED TO WAIT FOR 15 MINUTES (30 MIN IF I HAVE A HISTORY OF ANAPHYLAXIS) OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

Client/Parent/Guardian Signature: _____ Date: _____

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AREA BELOW FOR CLINIC USE ONLY

Clinic site: _____Cascade Health_____

Vaccine Mfg.	***Administration Date***	***Vaccination #***	***Dose***	***EUA Fact Sheet Provided***	***Lot #***	***Exp Date***
Pfizer	____/_____/_____	☐*First Dose* ☐*Second Dose*	0.3mL ≥ 12 yrs old	☐*Yes* ☐*No*		__/__/__
Moderna	____/_____/_____	☐*First Dose* ☐*Second Dose*	0.5mL ≥ 18 yrs old	☐*Yes* ☐*No*		____/____
J & J	____/_____/____	☐*Single Dose*	0.5mL ≥ 18 yrs	☐*Yes* ☐*No*		____/____

Site of IM injection: ☐ RDT ☐ LDT *or* _____

☐ Anderson, Ann RN
☐ Bailey, Roger, EMT
☐ Bryson, Barbara NP
☐ Buie, Gayle RN
☐ Davila, Michelle, NP
☐ deBroekert, Martha RN
☐ Demello, Penny MOA
☐ Dochnahi, Annie RN
☐ Dutton, Becky RN
☐ Galbraith-Bain, Deanne MOA
☐ Feldman, Cindi RN
☐ Freeman, Ryan, EMT
☐ Harvey, Nancy RN
☐ Kehl, Jennifer RN
☐ Knowlton, Karen RN
☐ Marks, Carla RN
☐ Marks, Steve MD
☐ Micheel, Shannon RN
☐ Michels, Deb RN
☐ Park, Jin NP
☐ Royer, Adrienne RN
☐ Rowe, Laurie RN
☐ Sahara, Mary Joy RN
☐ Shrank, Jan RN
☐ Spear, Sheila RN
☐ Stamps, Cindy MOA
☐ Vait, Rita RN

_____ _____ _____
Signature and Title of Vaccine Admin. **Date** **Time**

Vaccinator Comments: _____

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