COVID-19 Vaccine Consent Form

PERSONAL INFORMATION ABOUT INDIVIDUAL TO RECEIVE VACCINE					
Last Name	First Name		M.I.	Gender (circle) Male Female	
Date of Birth	Age	Race Ethnicity - Circle All that Apply: American Indian or Alaskan Native Asian or Pacific Islander Black or African American Hispanic or Latino White or Caucasian		Last 4 digits Social Security #	
Telephone Number	Alternate Number	Street Address		Apt. Number	
City	County	State	Zip Code		

INSURANCE INFORMATION				
Name of Insurance Company	Member ID Number/Contract Number	Group Number	Relationship to Subscriber (select) ☐ Self ☐ Spouse ☐ Other _____	
Subscriber Name (if different than patient)	Subscriber Birthdate	Subscriber Street Address, City, State, and Zip Code		
Secondary Insurance	Member ID /Contract Number	Group Number	Subscriber Name	

In the event of an emergency, please provide:		
Emergency Contact	Relationship	Telephone Number

PLEASE SELECT ALL THAT APPLY TO INDIVIDUAL GETTING VACCINATION:

Healthcare Worker:
___Inpatient
__Outpatient
___Long term Care Facility
__Home Health/Hospice
__Other HCW:

___Laboratory

__ Emergency Medical Services
__Mortuary Services Provider

First Responder:
__Law Enforcement
__Fire Services
__Correction Officer
__ Other:

__Live or work in congregate or group setting (Group Home, Shelter, Correctional Facility
__*Condition that puts one at high risk of severe illness or death from COVID-19
__Work (paid/unpaid) in a K-12 school -educators, administrators, bus drivers, support staff
__Work in one of the following**:** Food and Agriculture, Transportation and Logistics, Manufacturing, Public Safety, Food Service, Energy, Water and Waste Management, Legal, Media, Finance, Public Health
__ Age 65 and older
__None of the categories apply to the individual getting vaccinated

*Cancer, Chronic Kidney Disease, COPD, Heart conditions, Immunocompromised, Obesity and Severe Obesity, Pregnancy, Sickle Cell Disease, Smoking, Type 2 Diabetes, Asthma, Cardiovascular Disease, Cystic Fibrosis, High Blood Pressure, Neurologic conditions such as dementia, Liver Disease, Overweight, Pulmonary Fibrosis, Type 1 Diabetes Mellitus

VACCINATION AND HEALTH-RELATED NFORMATION: **If you answer Yes to questions 1 - 4, consult a health care provider.**	YES	NO
1. Does the patient have long-term health problems with: immunocompromised condition or taking a medicine that affects your immune system; heart disease; lung disease; asthma; kidney or liver disease; metabolic disease such as diabetes; bleeding disorder or take blood thinner		
2. Has the patient had life-threatening reaction to any injectable medication, COVID-19 vaccine, or to a vaccine component (example eggs, thimerosal, gelatin, neomycin, phenol, or bovine protein? Yes, list:		
3. For Women: Are you pregnant or considering becoming pregnant in the next three months or currently nursing? If male, circle: NA		
4. Has the patient had a seizure or any other brain or other nervous system problem (i.e., Guillain-Barre Syndrome) after receiving vaccine?		
Has the patient ever received COVID-19 vaccination? If yes, date given:_____ Manufacturer:		

I have read or have had explained to me the information in the Vaccine Fact Sheet or Vaccine Information Statement (VIS) about the Vaccine and a EUA Fact Sheet or VIS has been provided to me. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of requested Vaccine and ask that the Vaccine be given to me. I have reviewed the notice of my privacy rights and I have access to a copy of the Jefferson County Department of Health (JCDH) "Notice of Privacy Practices". I understand I can also access this information on JCDH's website. I understand my information and Vaccine(s) I receive will be entered into the Alabama Department of Public Health Immunization Registry. I give my permission for my insurance company to be billed and authorize payment directly to JCDH. I waive and release all claims I, or anyone claiming by or through me, now have or may hereafter acquire against JCDH, and their respective directors, officers, employees, and agents for any damage or injuries if I, or the person named above for whom I am authorized to make this request, contract the illness prevented by the Vaccine, other diseases, or suffer any other adverse reactions following administration of this Vaccine.

_____ _____

Signature of Individual/Parent/Legal Guardian Date

For Clinic Use Only

Clinic Site JCDH Community	Date Vaccine and VIS/Fact Sheet Given	Type and Date of VIS or EUA Fact Sheet **Moderna EUA 12/2020**			JCDH Patient Yes No		
Vaccine Given __ Moderna 1st Dose __Moderna 2nd Dose	Manufacturer Moderna	Lot # (Circle)	NDC # 80777-273-99	Exp. Date (Circle)	Injection Site LA RA	Route IM	Dose 0.5 ml
Nurse Signature					Date		

Notes: