ADHS COVID-19 Vaccine Consent Form

Use this form in conjunction with the CDC Pre-Vaccination Checklist for COVID-19 Vaccines.

(Staff only) Appointment ID: ____________________

Patient Information

Last Name | First Name | Middle Name (optional)

Mother's Maiden Name (Optional) | Date of Birth (MM/DD/YYYY) | Gender

Address | Apartment Number | City | State | Zip

○ **No address available**

Phone Number

Email Address

Insurance Information

Do you have insurance? ○ **Yes** ○ **No**

Plan Name | Plan Group ID # | Plan Individual ID #

Name of Person Covered By Plan | Plan Responsible Person Name

Private Insurance Address and Phone Number (If Available)

CONSENT AND ASSIGNMENT OF BENEFITS: *I have had a copy of the Emergency Use Authorization for the COVID-19 vaccine made available to me. I have had a chance to ask questions and I believe I understand the benefits and risks of the COVID-19 vaccines requested. I ask that the vaccines be administered to me or the person for whom I am authorized to make this request.*

I certify that I am: (1) the patient and at least 18 years of age; (2) the legal guardian of the patient and the patient's age makes him/her eligible to receive the vaccine based on the current emergency use authorization; or (3) a person authorized to consent on behalf of the patient where the patient is unable to consent for themselves.

I hereby assign to ______________________ any insurance or other third-party benefits available for the administration fee of the COVID-19 vaccine provided to me. I agree to forward to ______________________ all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

I agree to allow the health care provider to release information to the Arizona State Immunization Information System (ASIIS) to record that I (or for the person for whom I am authorized to consent) have received this COVID-19 vaccine. This information will help keep track of the manufacturer and doses of the vaccine.

Patient Printed Name | Patient Signature | Date Signed

Parent/Guardian/Authorized Person Printed Name | Authorized Person's Signature | Date Signed

Vaccine Administration Information for Immunizer Use Only

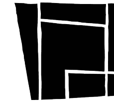
Administration Date | Manufacturer | NDC # | ○ LEFT ARM | ○ RIGHT ARM

Lot Number | Expiration Date | Route | Site

Administering Immunizer Name and Title | Administering Immunizer Signature

Is this the patient's first, second, or third dose? **First** **Second** **Third**

COVID-19 Screening Questions



ARIZONA DEPARTMENT OF HEALTH SERVICES
PREPAREDNESS

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "Yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you feeling sick today?	◯	◯	◯
2. Have you ever received a dose of COVID-19 vaccine? ____________________ If yes, which vaccine product?	◯	◯	◯
3. 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?	◯	◯	◯
• Was the severe allergic reaction after receiving a COVID-19 vaccine?	◯	◯	◯
• Was the severe allergic reaction after receiving another vaccine or injectable medication?	◯	◯	◯
4. Do you have a bleeding disorder or are you taking a blood thinner?	◯	◯	◯
5. Have you received passive antibody therapy as treatment for COVID-19?	◯	◯	◯

For more information, please refer to the CDC pre-vaccination form for the specific vaccine you are giving.

Vaccine Administration Information for Immunizer Use Only

Administration Date | Manufacturer | NDC #

◯ LEFT ARM ◯ RIGHT ARM

Lot Number | Expiration Date | Route | Site

Administering Immunizer Name and Title | Administering Immunizer Signature