# ***PRESCRIPTIONS TO GEAUX*** *COVID-19 VACCINE CONSENT FORM* ***(2ND DOSE)***

**Information about person to receive vaccine (please print)**

**Name**: ___________________________________ **Birth date**: ___/___/_____ **Age**: _______ **Sex**: ☐ Male ☐ Female

**Race**: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other **Ethnicity**: ☐Hispanic ☐Non-Hispanic

**Address**: _________________________________ **City**: ____________________________ **State**: ______ **Zip**: _______

**Phone**: ________________________________ **Medicare Part B Number (Red, White & Blue)**______________________

**The following questions will help determine if there is any reason you should not receive your 2nd COVID immunization injection.**

*Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.*

| Question | | |
|---|---|---|
| Did you have any adverse reactions to your first Pfizer COVID-19 vaccination? | ☐ No | ☐Yes |
| If yes, list: _________________________________________________________ | | |
| Has the person to be vaccinated developed any **NEW** allergies since the initial dose? | ☐ No | ☐Yes |
| If yes, list: _____________________________________________ | | |
| Has the person to be vaccinated tested positive for COVID-19 since the initial dose? | ☐ No | ☐Yes |
| Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner? | ☐ No | ☐Yes |
| Has the person to be vaccinated received any other vaccines in the past 14 days? | ☐ No | ☐Yes |
| Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19? | ☐ 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). I authorize my insurance benefits be paid directly to Prescriptions to Geaux.

***I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING***

Client/Parent/Guardian Signature: ________________________________________________Date: ________________

____________________________________**FOR CLINIC USE ONLY**_______________________________________________

***Clinic site***: ______________________________________ ***EUA Fact Sheet Provided***: *Yes* *No*

***Date 1st vaccine administered***: ____/____/_____ ***Date 2nd Dose (booster) vaccine administered***: ____/____/_____

***Site of IM injection***: *RDT or LDT or* _______ ***Dose***: *0.3ml*

***Vaccine manufacturer***: _______________

***Lot number***: ________________________

***Signature and title of vaccine administrator***: _________________________________________________________________

***Comments***: _____________________________________________________________________________________