PRESCRIPTIONS TO GEAUX *COVID-19 VACCINE CONSENT FORM (**1ST 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: _____ **Do you have insurance?** ☐No ☐Yes **SSN:** _____

The following questions will help determine if there is any reason you should not receive a COVID-19 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.

Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex?	☐ No	☐Yes
List all allergies: _____		
Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy?	☐ No	☐Yes
Is the person to be vaccinated sick today?	☐ No	☐Yes
Is the person to be vaccinated at least 18 years old?	☐ No	☐Yes
If no, is the person to be vaccinated at least 12 years old?	☐ 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 Name: _____ Signature: _____Date:_____

FOR CLINIC USE ONLY

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

Date vaccine administered: ____/____/_____ ***Date booster required***: ____/_____/_____

Vaccine manufacturer: _____

Lot number: _____

Site of IM injection: *RDT or LDT or* _____ ***Dose***: *0.3ml 0.5ml*

Signature and title of vaccine administrator: _____

Comments: _____