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: _____ **Do you have insurance?** ☐No ☐Yes **SSN:** _____

The following questions will help determine if there is any reason you should not receive your 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.

Did you have any adverse reactions to your first 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
Which COVID-19 vaccine did you receive for your first dose (circle):	MODERNA PFIZER

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 1st vaccine dose administered: ____/____/_____ ***Date 2nd vaccine dose administered***: ____/____/_____

Date booster required: ____/_____/_____

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

Vaccine manufacturer: _____

Lot number: _____

Signature and title of vaccine administrator: _____

Comments: _____