

# PRESCRIPTIONS TO GEAUX COVID-19 VACCINE CONSENT FORM (3<sup>RD</sup> BOOSTER 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: \_\_\_\_\_ 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 previous COVID-19 vaccination?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, list: _____	
Has the person to be vaccinated developed any <b>NEW</b> allergies since the previous dose?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, list: _____	
Has the person to be vaccinated tested positive for COVID-19 since the previous dose?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has the person to be vaccinated received any other vaccines in the past 14 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If this is your 3 <sup>rd</sup> (booster) dose, when did you receive your 2 <sup>nd</sup> COVID-19 dose? _____	
Which COVID-19 vaccine did you receive for your previous 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 1<sup>st</sup> vaccine administered: \_\_\_/\_\_\_/\_\_\_ Date 2<sup>nd</sup> Dose vaccine administered: \_\_\_/\_\_\_/\_\_\_

Date 3<sup>rd</sup> Dose vaccine administered: \_\_\_/\_\_\_/\_\_\_

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: \_\_\_\_\_