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**COVID-19 Vaccine**

**INFORMATION AND CONSENT FORM**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **NAME** (Last) | | (First) | | Date of Birth:  \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ | | **Age:** | |
| **ADDRESS** | | | | | | | |
| **CITY** | **STATE** | **ZIP** | | **DAYTIME PHONE NUMBER** | | | |
| **EMERGENCY CONTACT: Name Relation Phone Number** | | | | | | | |
| **Race: (check only 1)**  Asian/Polynesian Black Multiracial Native Am/Alaskan White Unknown | | | **Ethnicity: (check only 1)**   Not Hispanic   Hispanic Unknown | | **Primary Language:**   English  Other \_\_\_\_\_\_\_\_\_\_\_ | | **Gender:**  Male   Female |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please answer the health questions below:** | **Yes** | **No** | **Do Not Know** |
| 1. Are you feeling sick today? |  |  |  |
| 2. Have you ever received a dose of COVID-19 vaccine?  \*If yes, vaccine product and the date administered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 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 reaction after receiving a COVID-19 vaccine? |  |  |  |
| \*Was the severe reaction after receiving another vaccine or another injectable medication? |  |  |  |
| 4. Have you received another vaccine in the last 14 days? |  |  |  |
| 5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? |  |  |  |
| 6. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? |  |  |  |
| 7. Do you have a bleeding disorder or are you taking a blood thinner? |  |  |  |
| 8. Are you pregnant or breastfeeding? |  |  |  |

|  |
| --- |
| I have been given a copy and have read the Emergency Use Authorization (EUA) and reviewed the FDA Fact Sheet for Recipients and Caregivers for the COVID-19 vaccine product I will be administered (choose one of the following):  \_\_\_\_\_\_ Pfizer (age 12 & over); \_\_\_\_\_ Moderna (age 18 and over); \_\_\_\_\_ Janssen (age 18 and over). I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine indicated and ask that it be given to me or the person named for whom I am authorized to make this request.  **My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine.**  **Those with previous anaphylactic reactions should stay for 30 minutes.**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date Print Name Patient or Parent/Guardian** **Signature** |
| **FOR ADMINISTRATIVE USE ONLY**  **Vaccine recipient provided:**   Pfizer <https://www.fda.gov/media/144414/download>   Moderna <https://www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-recipients.pdf>   Janssen <https://www.janssenlabels.com/emergency-use-authorization/Janssen+COVID-19+Vaccine-Recipient-fact-sheet.pdf>   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Vaccine** | **Dose** | **Route** | **Date Administered** | **Vaccine Manufacturer** | **Lot Number** | **Expiration Date** | **Name of Vaccine Administrator** | | COVID-19 | \_\_\_\_\_ml 1st  \_\_\_\_\_ml 2nd | ⁭ IM - L Arm  ⁭ IM - R Arm |  |  |  |  |  | |

**HRSA Covid- 19 Uninsured Information**

**(all fields are required to be filled for processing)**

**Date of Service**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patients Full Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Middle Initial

**Gender\_**\_\_\_M / F\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mr./ Mrs./Ms./ Child

**Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address Apt.#

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

**DOB:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# (**required**):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If the patient is a child under the age of 18, also add parent’s/ responsible party’s information below:**

**Parent’s Full Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Middle Initial

**Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address Apt.#

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drivers LIC#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Medical Consent Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby give my consent for the following test to be performed at PCG Molecular, LLC:

\_\_\_COVID-19 Nasal Test

\_\_\_COVID-19 Nasal Rapid Test (not covered by insurance) *Official Use Only: Paid Y/N*

 \_\_\_COVID-19 Antibody Test

\_\_\_COVID-19 Saliva Test

\_\_\_COVID-19 Vaccine (Pfizer, Moderna, & Janssen)



(Patient Printed Name) (Date)

(Patient Signature) OFFICAL USE ONLY BELOW