Fergus County Nurses Office

COVID-19 Vaccine Consent Form

Client Last Name, First Name

Client Name:_____/_____/_____ ☐Male ☐Female
First M.I. Last

Date of Birth:_____/_____/_____Age_____Phone_____

Address:_____ City: _____ State: _____ Zip:_____

Client's race (Please check all that apply): _____White _____Native American/Alaska Native _____Asian _____ African American _____Native Hawaiian/Pacific Islander _____Other_____

Is the client of Hispanic or Latino origin? Yes _____No_____

Primary Source of Insurance: (please check one) ☐ Insurance ☐None ☐ Other_____

Insurance Company Name: _____

Insurance Subscriber's Name: Subscriber's Birth Date: / /

Relationship to Subscriber:
Self ☐ Spouse ☐Child ☐ Other ☐

Policy Number or Member ID:

Screening Questions:	Dose #1 Date:_____	Dose #2 Date:_____
1. Are you feeling sick today?	YES / NO	YES / NO
2. Have you ever received a dose of COVID-19 vaccine?	YES / NO	YES / NO
• If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Another product _____		
3. Have you ever had an allergic reaction to: component of the COVID Vaccine, including polyethylene glycol(PEG), polysorbate, a previous dose of COVID-19 vaccine, any vaccine, an injectable medication, foods, pet, environmental, or oral medications?	YES / NO	YES / NO
4. Have you received any vaccine in the last 14 days?	YES / NO	YES / NO
5. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you have had COVID-19?	YES / NO	YES / NO
6. Have you received passive antibody therapy as treatment for COVID19?	YES / NO	YES / NO
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	YES / NO	YES / NO
8. Do you have a bleeding disorder or are you taking a blood thinner?	YES / NO	YES / NO
9. Are you pregnant or breastfeeding?	YES / NO	YES / NO
10. Do you have dermal fillers?	YES / NO	YES / NO

I have read the Vaccine Information Sheet(s) and have had a chance to ask questions. The risks and benefits have been explained to me or the person named for who I am authorized to make this request. I give the consent without coercion or reservation. I authorized my health care provider and a public health agency to collect and enter my child's immunization record into the Department of Public Health and Human Services' Immunization Information System (IIS) or imMTrax. The IIS is a confidential, computer system that contains Immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department. The above information is true to the best of my knowledge. I authorize Fergus County Nurse's Office to bill my insurance and agree benefits be paid directly to the (Fergus County Nurse's Office). I understand that I am financially responsible for any balance. I also authorize (Fergus County Nurse's Office) or my Insurance Company to release any information required to process my claim(s). I also give permission to the (Fergus County Nurse's Office) to release health care information regarding any vaccinations or reactions to the Health Care Provider I have specified.

X_____ Date: _____
Signature of Legally Responsible Person

For Office Use Only

Date of service: _____ Form:5/10/2021 COVID Dose #1 Site: RA LA Route: IM Lot: _____ Exp. Date: _____ Manufacturer: Pfizer RN Signature	Date of service: _____ Form: 5/10/2021 COVID Dose #2 Site: RA LA Route: IM Lot: _____ Exp. Date: _____ Manufacturer: Pfizer RN Signature