


ISLAND DRUG

LA CONNER DRUG
COVID-19 VACCINE CONSENT FORM

Name: _____ Birth date: _____ Age: _____

Race: Asian Black Native American Pacific Islander White Other Declined

Ethnicity: Hispanic Non-Hispanic Other Declined Sex: Male Female Undifferentiated/Unknown Other

Allergies: None Penicillin Sulfa Codeine Erythromycin Other _____

Conditions: None Diabetes High Blood Pressure High Cholesterol Asthma Pregnancy Other: _____

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

Email Address (type VERY clearly): _____

Cell Phone: _____ Home Phone: _____

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

Has the person to be vaccinated ever received a COVID-19 vaccine? No Yes

If yes, date: _____ Type/Brand of COVID vaccine: _____

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 16 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 also received the Notice of Privacy Practices.

I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

Print Parent/Guardian name, if different from client: _____

Client/Parent/Guardian 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: _____

INSURANCE INFORMATION

(Please give your insurance card AND to the receptionist **OR PLEASE include images below**)

Primary Insurance: _____

Subscriber's Name: _____ Date of birth: _____

Group No: _____

Policy No: _____

Client's relationship to subscriber: _____

Secondary Insurance: _____

Subscriber's Name: _____ Date of birth: _____

Group No: _____

Policy No: _____

Client's relationship to subscriber: _____

The above information is true to the best of my knowledge. If qualified, I authorize billing to my insurance company and release of information required to process my claims.

Client Signature _____ Date _____

Insurance Card AND Identification images below