COVID-19 Vaccine Consent Form

Section 1: Information about Person to Receive Vaccine (please print)

RESIDENT'S NAME (Last)	(First)	(M.I.)	**RESIDENT'S DATE OF BIRTH** **month_____day_____year_____**
HEALTH CARE POWER OF ATTORNEY / LEGAL GUARDIAN NAME (Last) (First) (M.I.)			**RESIDENT'S AGE** / **RESIDENT'S GENDER** **M / F**
			GUARDIAN DAYTIME PHONE NUMBER:
CITY	**STATE**	**ZIP**	
RESIDENT'S PRIMARY CARE PROVIDER'S NAME (Last Name and Credential, First Name)			
FACILITY NAME	**ROOM NUMBER**		

Section 2: Screening for Vaccine Eligibility

Please mark YES or NO for each question.

1. Has this person been confirmed to have had the COVID-19 virus? YES ☐ NO ☐
2. Has this person been vaccinated with the COVID-19 vaccine? YES ☐ NO ☐

If yes to #2 above, there are two kinds of COVID-19 vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine your person can get.
Vaccine Brand (Pfizer or Moderna): _____ Date given: month_____day_____year_____

Section 3: Consent

I have read or had explained to me the Vaccine Information Statement (VIS) for the COVID-19 vaccine and understand the risks and benefits.

☐ **I GIVE CONSENT** to the _____NAME OF ORGANIZATION CONDUCTING CLINIC and its staff for my person named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then this person will not be vaccinated)

☐ **I DO NOT GIVE CONSENT** to the _____NAME OF ORGANIZATION CONDUCTING CLINIC and its staff for this person named at the top of this form to be vaccinated with this vaccine.

Signature / Printed Name of Health POA or verbally acknowledged by licensed staff (sign & print name & credentials)

_____

Date: month_____day_____year_____