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 _____**	
AUTHORIZED POWER OF ATTORNEY (POA) /LEGAL GUARDIAN NAME (Last)	(First)	(M.I.)	**RESIDENT'S AGE**	**RESIDENT'S GENDER** ☐ **M /** ☐ **F**
			AUTHORIZED POA PHONE NUMBER:	
CITY / **STATE**	**ZIP**			
RESIDENT'S PRIMARY CARE PROVIDER'S NAME (Last)	(First)		(Middle Initial)	
FACILITY NAME	**ROOM NUMBER**			

Section 2: Screening for Vaccine Eligibility

1. Has this person been vaccinated with the COVID-19 vaccine? YES ☐ NO ☐

If yes to above, there are multiple kinds of COVID-19 vaccine. Your answers to the following questions will help us understand which vaccine (or step) to provide.

Vaccine Brand (**Pfizer, Moderna, Astra Zeneca, Johnson and Johnson**): _____

Date dose #1 given: *Month* _____ *Day* _____ *Year* _____

Date dose #2 (*if necc*) given: *Month* _____ *Day* _____ *Year* _____

Section 3: Consent

I understand I will be provided an Emergency Use Authorization Fact Sheet or a Vaccine Information Statement prior to the date of the vaccination and have the ability to revoke consent at any time

☐ **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.

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

_____

Date: *Month* _____ *Day* _____ *Year* _____