HEALTHDIRECT
PHARMACY SERVICES
Personalized care. Direct to you.

COVID-19 Vaccine Consent Form

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

☐ Resident ☐ Staff

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

FOR STAFF receiving COVID-19 Vaccination, please complete the following information. ***Check here if uninsured*** ☐

Drug Insurance Co. ID# PH #

Group # BIN# PCN#

Primary Cardholder? Yes ☐ No ☐ Primary Name Primary DOB

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 have read or had explained to me the Emergency Use Authorization Fact Sheet or a Vaccine Information Statement 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.

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* _____