COVID-19 + FLU VACCINE CONSENT FORM

Information about person to receive vaccine (please print)

Name: _____ **Birth date**: _____ **Age**: _____ **Sex**: ☐ Male ☐ Female

Race: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other **Ethnicity**: ☐Hispanic ☐Non-Hispanic

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

Phone: _____ **Do you have Medicare or Medicaid?** ☐No ☐Yes--Number:_____

Do you have insurance? ☐No ☐Yes Company:_____ Policy/ID#:_____

Please list policyholder name, date of birth & address, if not you: _____

The following questions will help determine if there is any reason you should not receive a COVID or Influenza immunization.
Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.

Has the person to be vaccinated ever received a COVID-19 vaccine?	☐ No ☐Yes
If yes, date(s):_____ Type/Brand of COVID vaccine:_____	
If yes, and if the initial vaccination series is complete, is the person seeking a **booster** dose? (Recommended for all individuals 12 years and older, 5 mo. after Pfizer, 6 mo. after Moderna, 2 mo. after J&J)	☐ No ☐Yes
Does the person attest to having a qualifying moderate/severe immunocompromising condition? (e.g. cancer treatment, organ transplant, etc.) If yes, it is recommended to receive an **additional, full** dose, at least 28 days after initial series completion.	☐ No ☐Yes
Please indicate the age of the person to be vaccinated:	☐ 18 years or older ☐ 5-11 years old ☐ 12-17 years old ☐ 6 mo.- 5 years old
Does the person to be vaccinated have an allergy to any medications, food (including eggs), vaccine, or latex? List all allergies: _____	☐ No ☐Yes
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
Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner?	☐ No ☐Yes
Does the person to be vaccinated have a history of myocarditis or pericarditis?	☐ No ☐Yes
Has the person to be vaccinated received passive antibody therapy as a treatment for COVID-19?	☐ No ☐Yes

Additional Questions for Influenza Vaccine:

Has the person to be vaccinated received a flu (influenza) vaccine before?	☐ No ☐Yes
Did the person to be vaccinated have any problems with a previous flu vaccine?	☐ No ☐Yes
Does the person to be vaccinated have a history of Guillian-Barre Syndrome (a paralysis problem)?	☐ No ☐Yes
Has the person to be vaccinated received a Pneumonia vaccine? If yes, in what year? PPSV23 _____ PCV13_____	☐ No ☐Yes

I have read, or have had explained to me, the Vaccine Information Statement (VIS,) or the Emergency Use Authorization (EUA) for COVID-19 and Influenza 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 and Influenza vaccine and ask that the vaccine(s) be given to me or the person named above for whom I am authorized to make this request (parent or guardian). I have received and read the Wyoming Department of Health Notice of Privacy Practices and have had a chance to ask questions about how my information will be used. If qualified, I authorize billing to my insurance company and release of information required to process my claims. I authorize my insurance benefits be paid directly to _____ County Public Health. **I HAVE BEEN ADVISED TO WAIT FOR 15 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.**

X **Client/Parent Signature**: _____Date: _____

Print name if guardian or parent:_____

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Influenza Dosage Schedule:

Age Group	Dosage Schedule
9 Years and older	**0.5ML: One dose**
6 Months – 8 Years	**0.5 ML: One dose*†**

** For children younger than 9 years of age, refer to the 2021 ACIP Recommendations to determine the need for one or two doses. If two doses are needed, separate the doses by at least 4 weeks.*

†Dosage for age may vary by brand of vaccine. See package insert.

Clinic site: _____ ***Date of vaccines***: _____

COVID VACCINE: ***Date 2nd dose due:*** _____

VIS/EUA Fact Sheet Provided: (Yes) No ***Pfizer*** *0.2ml* ***Pfizer*** *0.3ml* ***Moderna*** *0.5ml* ***Moderna*** *0.25ml* ***J&J*** *0.5ml*

Site of IM injection: *RDT or LDT or* _____ ***Lot number***: _____

INFLUENZA:

VIS Fact Sheet Provided: (Yes) No ***Booster Required? Yes No Date:***_____

Site of IM injection: *RDT or LDT or RLT or LLT* ***Mfctr &Lot number***: _____

Signature & title of vaccine administrator: _____

Comments:

Billed WYIR