

Consent for COVID-19 Vaccination



Complete the following for the person who is being vaccinated:

Name: FIRST _____ MIDDLE _____ LAST _____

Phone: () _____ - _____ Birth Date: ____ / ____ / ____ Age: _____ Sex: F M

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Parent/Guardian Full Name: _____ Parent Cell Phone# _____

Ethnicity: Hispanic/Latino Not Hispanic/Latino

Race: (Check all that apply) American Indian/Alaskan Native Asian Black Native Hawaiian/Pacific Islander
 White Unknown

Insurance Status (Check box)

NO INSURANCE

MEDICAID

Company: _____ Medicaid #: _____ Don't know

PRIVATE or COMMERCIAL INSURANCE (NOT MEDICAID)

Insurance Company: _____ Insurance Policy ID: _____

Group # _____ (if one applies) Policy Holder Name: _____

Policy Holder Birth Date: ____ / ____ / ____ SSN: _____

Policy Holder Relationship to Patient: _____

Questions for the person getting vaccinated:

- | | NO | YES |
|--|--------------------------|---|
| 1. Is the person to be vaccinated sick today? If yes, what are their symptoms? | <input type="checkbox"/> | <input type="checkbox"/> , symptoms: _____ |
| 2. Does the person to be vaccinated have any allergies to medications, foods, a vaccine component, or latex? | <input type="checkbox"/> | <input type="checkbox"/> , allergies: _____ |
| 3. Has the person to be vaccinated ever had a serious reaction to a vaccine in the past? If yes, please explain: | <input type="checkbox"/> | <input type="checkbox"/> , explain: _____ |
| 4. Has the person to be vaccinated ever had Guillain-Barre Syndrome (GBS)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. For women: Is the person to be vaccinated pregnant or is there a chance they could be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has the person to be vaccinated received any vaccinations in the past 2 weeks? | <input type="checkbox"/> | <input type="checkbox"/> |

By signing below, I consent to the use and disclosure of my or my child's personal health information for the purpose of health care operations, along with the assignment of all payments from the insurer listed above to Indiana Department of Health (IDOH) for the services rendered.

Consent for use of protected health information & claims assignment: I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payment from the insurance provider (if applicable) to IDOH for administration of the COVID - 19 vaccination.

Vaccine authorization: My signature on this form indicates that I have requested that the COVID-19 vaccine be administered to me or my dependent by a vaccination clinic representative. I acknowledge that I have received information concerning the risks and benefits of the COVID - 19 vaccine and that I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the risks and benefits of the COVID - 19 vaccine and consent to the administration of the vaccine to me or my dependent.

Signature of Parent or Guardian _____ Date: _____
If student under 18 years of age