COVID- 19 Vaccine Consent Form

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

(Last Name) (First Name) (M.I.) Date of Birth (mm/dd/yyyy)

☐ M ☐ F

Age Gender Facility Name Room Number (if applicable)

American Indian/Alaska Native Asian Native Hawaiian/Other Pacific Islander
Black/African American White Other Race Unknown Choose to opt out of reporting
*Race (Optional Circle One)

Hispanic/Latino Not Hispanic/Latino
Unknown Ethnicity Choose to opt out of reporting
*Ethnicity (Optional Circle One)

*Note: Race and Ethnicity are reported to the CDC COVID Vaccine Program

Section 2: If applicable please provide Legal Guardian/Power of Attorney (POA) Information

( )

(Last Name) (First Name) (M.I.) Phone Number

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 understand that this consent will be for the series of vaccines to complete the COVID vaccine.

☐ **I GIVE CONSENT** to *Consonus Pharmacy Services* 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 *Consonus Pharmacy Services* and its staff for this person named at the top of this form to be vaccinated with this vaccine.

Signature: ☐ Patient signature ☐ Health POA ☐ Health POA/Verbally acknowledged by licensed staff

Signature Date (Month/Date/Year)

Print Name (First and Last Name) Date (Month/Date/Year)

Section 4: ONLY complete if Facility Staff OR Not a Current Consonus Customer

Although the COVID-19 vaccine is provided free of charge by the federal government, medial insurance information is needed for administration fees to be collected for those supplying the vaccine. Please provide the information below.

Rx Coverage Insurance Carrier Cardholder ID BIN PCN

☐ Yes ☐ No

Are you the primary card holder? If no, please provide Primary cardholder's DOB.

Primary Care Provider Name -PCP (Last Name) (FirstName) (M.I.)

( ) ( )

PCP Phone Number PCP Fax Number

PCP Address City State Zip

If uninsured, you must attest that the following information is true and accurate:

☐ I do not have any insurance, including but not limited to Medicare, Medicaid or any other private or government funded health benefit plan.

In order to have your vaccine administration fee paid for by the United States Health and Resources and Services Administration's COVID-19 Program for Uninsured Patients, please provide ONE of the following.

☐ Social Security Number
Number

☐ State ID Number and State of Issuance
Number State

☐ Drivers' License Number and State of Issuance
Number State