COVID-19 Vaccine Consent Form

KNOX PUBLIC HEALTH

Patient Information (Please Print)			
Name:	**Date of Birth/Age:**	**Phone #:**	
Home Address:		**SS# or DL#**	
City:	**State:**	**Zip:**	**County:**
Gender:	**Race:**	**Ethnicity:** Hispanic/Latino **or** Not Hispanic/Latino	
Do you live within Mount Vernon city limits? **Yes** ☐ **No** ☐			

Insurance Information	
Medicare Plan/Number:	**Medicaid Plan/Number:**
Private Insurance Company Name:	
Member ID#	**Group #**
Insured Name/DOB:	**Relationship to Insured:**

Please answer the following questions	
1. Are you sick today?	☐ YES ☐ NO
2. Have you ever had a serious (anaphylactic) reaction after receiving a vaccination?	☐ YES ☐ NO
3. Are you taking any medications that lower the body's resistance to infection?	☐ YES ☐ NO
4. Females Only: Are you currently pregnant or breastfeeding?	☐ YES ☐ NO
5. Have you received any vaccines in the past two weeks?	☐ YES ☐ NO
6. Have you received any previous doses of mRNA COVID 19 vaccine (Pfizer or Moderna)? **7. If yes, how many doses?** **Pfizer ◯1 ◯2 ◯3 ◉4+** **Moderna ◯1 ◯2 ◯3 ◯4+**	☐ YES ☐ NO

The Knox Public Health or Health Center may keep this record in your medical file. They will record what vaccine was given, date the vaccine was given, the name of the company that made the vaccine, the vaccine special lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given. I understand that this information will be released to a state-wide Immunization Registry for the purpose of immunization tracking recall and recording, unless I request otherwise. I have read or have had explained to me the Vaccine Information Sheet about COVID-19 disease and the COVID-19 vaccine. I have had a chance to ask questions, and they were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to the person named above for whom I am authorized to make this request. Your medical information is never shared without an authorization to release information. A copy of Knox Public Health's Notice of Privacy Practices (HIPAA) will be provided upon request, and it is also located on our website at www.knoxhealth.com.

Patient/Guardian Signature: _____ Date: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY

COVID-19 Vaccine	Injection Site: IM	Vaccine Manufacturer:	Vaccine Administrator Signature:
__ VFC __317 __Prvt __ Bridge __E-clinical	___RD ___ LD ___RVL ___LVL	_____ Lot #_____ Expiration: _____	_____ Date_____

Revised 10/10/23 TLC