ADHS COVID-19 Vaccine Consent Form

ARIZONA DEPARTMENT OF HEALTH SERVICES
PREPAREDNESS

Patient Information

Last Name | First Name | Middle Name (optional)

Mother's Maiden Name | Date of Birth (MM/DD/YYYY) | Gender

Address | Apartment Number | City | State | Zip

◯ **No address available**

Phone Number

Is this the patient's first or second dose? ◯ **First** ◯ **Second**

Insurance Information

Do you have insurance? ◯ **Yes** ◯ **No**

ASSIGNMENT OF BENEFITS I hereby assign to Salt River Integrated Health Care any insurance or other third-party benefits available for the administration fee of the COVID-19 vaccine provided to me. I agree to forward to Salt River Integrated Health Care all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.
I agree to allow the health care provider to release information to the Arizona State Immunization Information System (ASIIS) to record that I (or for the person for whom I am authorized to consent) have received this COVID-19 vaccine. This information will help keep track of the manufacturer and doses of the vaccine.
I have had a copy of the Emergency Use Authorization for the COVID-19 vaccine made available to me. I have had a chance to ask questions and I believe I understand the benefits and risks of the COVID-19 vaccines requested. I ask that the vaccines be administered to me or the person for whom I am authorized to make this request.

Patient Printed Name | Patient Signature | Date Signed

Authorized Person's Printed Name (if applicable) | Authorized Person's Signature | Date Signed

Relationship to Minor who is receiving this COVID-19 vaccine

COVID-19 Screening Questions

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "Yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?	◯	◯	◯
2. Have you ever received a dose of COVID-19 vaccine?	◯	◯	◯
If yes, which vaccine product? _____			
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?	◯	◯	◯
• Was the severe allergic reaction after receiving a COVID-19 vaccine?	◯	◯	◯
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?	◯	◯	◯
4. Do you have a bleeding disorder or are you taking a blood thinner?	◯	◯	◯
5. Have you received passive antibody therapy as treatment for COVID-19?	◯	◯	◯

For more information, please refer to the CDC pre-vaccination form for the specific vaccine you are giving.

Vaccine Administration Information for Immunizer Use Only

Administration Date _____ Manufacturer _____ NDC # _____

◯ LEFT ARM ◯ RIGHT ARM

Lot Number _____ Expiration Date _____ Route _____ Site _____

Administering Immunizer Name and Title _____ Administering Immunizer Signature _____