COVID-19 Vaccine Consent Form

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

RESIDENT'S NAME (Last)		(First)	(M.I.)	RESIDENT'S DATE OF BIRTH month_________ day________ year __________	
AUTHORIZED POWER OF ATTORNEY (POA) /LEGAL GUARDIAN NAME (Last)		(First)	(M.I.)	RESIDENT'S AGE	RESIDENT'S GENDER ☐ M / ☐ F
CITY	STATE	ZIP		AUTHORIZED POA PHONE NUMBER:	
RESIDENT'S PRIMARY CARE PROVIDER'S NAME (Last)			(First)		(Middle Initial)
FACILITY NAME		ROOM NUMBER			

Section 2: Screening for Vaccine Eligibility

1. Has this person been vaccinated with the COVID-19 vaccine? YES ☐ NO ☐

If yes to above, there are multiple kinds of COVID-19 vaccine. Your answers to the following will help us understand which vaccine (or step) to provide.
Vaccine Brand (**Pfizer, Moderna, Astra, Johnson and Johnson**): ______________________________
Date dose #1 given: *Month* ____________ *Day* ____________ *Year* ____________
Date dose #2 (if necc) given: *Month* ____________ *Day* ____________ *Year* ____________
Date dose #3 given: *Month* ____________ *Day* ____________ *Year* ____________
Date dose #4 given: *Month* ____________ *Day* ____________ *Year* ____________

Section 3: Consent

I have read or had explained to me the Emergency Use Authorization Fact Sheet or a Vaccine Information Statement for the Covid-19 vaccine and understand the risks and benefits.

☑ **I GIVE CONSENT** to the Geriscript Pharmacy *NAME OF ORGANIZATION CONDUCTING CLINIC* 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 the Geriscript Pharmacy *NAME OF ORGANIZATION CONDUCTING CLINIC* and its staff for this person named at the top of this form to be vaccinated with this vaccine.

Resident signature OR Signature/Printed Name of Health POA OR Name of Health POA/verbally acknowledged by licensed staff (sign & print name & credentials)

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Date: *Month* ____________ *Day* __________ *Year* ____________