



## COVID-19 VACCINE CONSENT FORM

\*\*This form is to be used for patients aged 12 years of age and older ONLY\*\*

Revised 05/12/2021

Dose #1  
 Dose #2

Last Name: _____		First Name: _____		Middle Initial: _____
Birth Date: _____ <small>Month / Day / Year</small>		Mother's Maiden Name: _____ <small>First and Last Name</small>		
Mailing Address: _____		City: _____	State: <u>  </u> NM <u>  </u>	Zip: _____
<input type="checkbox"/> OR <input type="checkbox"/> Address is unavailable or temporary				
Daytime Phone: _____		Emergency Contact: _____ <small>First and Last Name</small>		Relationship: _____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race: <input type="checkbox"/> American Indian/Native American/Alaskan Native <input type="checkbox"/> Black/African American	<input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Other <input type="checkbox"/> White	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic

### INSURANCE INFORMATION – Fill the appropriate category – REQUIRED

Centennial Care/Medicaid: <input type="checkbox"/> Blue Cross Blue Shield <input type="checkbox"/> Presbyterian <input type="checkbox"/> Western Sky	
Policy/ Member ID # _____	Centennial Care Medicaid #: _____ Group #: _____
Medicare Part B: Subscriber ID # _____ Responsible Party: _____ Policy Holder's Date of Birth: _____	
<input type="checkbox"/> No Insurance	<input type="checkbox"/> Private Insurance

### MEDICAL SCREENING QUESTIONS - REQUIRED

<b>For patients:</b> The following questions will help us determine if you should be given the vaccine today. If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated. It just means that additional questions must be asked. If a question is not clear, please ask your health care provider to explain it.	No	Yes	Don't Know
1. Are you sick today?			
2. Do you have allergies to medications, food, a vaccine component, or other materials? Please list: _____ <i>If allergy to COVID vaccine, do not vaccinate until discuss with healthcare provider; if other allergy, monitor 30 min.</i>			
3. Have you ever had a serious reaction after receiving a vaccine, including a prior dose of COVID-19 vaccine?			
4. Do you have a bleeding disorder or are you taking a blood thinner? <i>If yes, be aware of possible bleeding/bruising.</i>			
5. Have you tested positive for COVID 19 in the last 10 days? <i>If yes, re-schedule vaccination for after isolation.</i>			
6. Have you received a COVID-19 vaccine in past? <i>If yes, be sure of timing and manufacturer for second dose (if indicated).</i>			
7. Have you received monoclonal antibody or convalescent plasma for COVID-19 treatment in last 90 days? <i>If yes, consult with provider: recommended re-schedule vaccination for 90 days after treatment.</i>			
8. Do you have an immune-suppressing condition or medicine? <i>If yes, be aware that vaccine effectiveness may be limited.</i>			

### CONSENT FOR VACCINATION

I have been given and have read or have had explained to me, the information in the “FACT SHEET FOR RECIPIENTS AND CAREGIVERS” for the vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine requested and ask that the vaccine checked below be given to me or the person named for whom I am authorized to make this request. I request that payment of authorized benefits be made to the New Mexico Department of Health/Public Health Division/Immunization Program, for services furnished to me by that program. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. I specifically authorize the release of my Medicare or other insurance policy number to the NM Department of Health to allow the Department of Health to seek reimbursement for the vaccine and administrative costs. Unless I sign a statement signifying otherwise, I allow immunization information to be entered into the New Mexico Statewide Immunization Information System (NMSIIS) and be released to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status. The DOH Privacy Policies are available at <http://nmhealth.org/hipaa.shtml> and will be given to all patients when they receive an immunization.

Signature (Client/Guardian): _____	Date: _____
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### FOR CLINIC USE ONLY

Vaccine	Lot #	Exp. Date	Site & Route	Date of EUA
COVID-19 Pfizer				
COVID-19 Moderna				
COVID-19 Janssen				
Vaccinator (print name): _____		Signature: _____		Date of Service: _____
Title of Vaccinator: _____		VFC Pin#: _____		Date Fact Sheet Given: _____
Date NMSIIS Entered: _____		Date TransactRx Entered: _____		Notes: _____
Address/location of vaccines given: _____				