COVID-19 Bivalent Booster Vaccine Consent

Cedar County Public Health
400 Cedar St. Tipton, IA

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	GENDER (circle one): Male Female Other

DATE OF BIRTH: ___ ___ / ___ ___ / ___ ___ ___ ___	AGE:	PHONE NUMBER:

STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

Vaccine Brand Requested (Moderna or Pfizer):	Allergies (Please list):

PLEASE ANSWER ALL QUESTIONS	CIRCLE ONE	
1. Have you previously completed your primary COVID-19 vaccination series?	YES	NO
2. Are you sick today? Been diagnosed with COVID-19 in the past 10 days or exposed to someone who has?	YES	NO
3. Have you received tixagevimab/cilgavimab (EVUSHELD) for COVID-19 pre-exposure prophylaxis? (see reverse)	YES	NO
4. Are you allergic to any foods, medications, vaccines, or latex? (For example: polysorbate, stool softeners, etc.?)	YES	NO
5. Have you ever had severe allergic reaction (anaphylaxis) requiring epinephrine, or for which you went to the hospital?	YES	NO
6. Do you have a bleeding disorder or are you taking a blood thinner?	YES	NO
7. If you are receiving this vaccine as a booster, do you meet eligibility criteria (including age and spacing between doses) to receive a **booster**?	YES	NO
8. **Did you experience a severe reaction following a previous dose of COVID-19 vaccine—including myocarditis or pericarditis?**	YES	NO

CONSENT FOR VACCINATION

- The Vaccine Information Sheet, or the Emergency use Authorization fact sheet have been made available to me and I understand the risks & benefits. I understand that this vaccine dose is authorized under Emergency use Authorization by the FDA for the prevention of COVID-19. I give consent to Cedar County Public Health to vaccinate the person named above and to record the vaccination in the Iowa Immunization Registry Information System (IRIS).
- I certify that the information I provided for payment and consent is correct. I authorize release of all records required to act on this request. I authorize Medicare, Medicaid, Blue Cross Blue Shield, or other insurance to make payments directly to Cedar County Public Health.

Patient/Guardian Signature: X _____ **Date:** _____

INSURANCE

INSURANCE COMPANY NAME: **UNINSURED** ◯

IDENTIFICATION NUMBER:

NAME OF CARD HOLDER:	BIRTH DATE OF CARD HOLDER: ___ ___ / ___ ___ / ___ ___ ___ ___

FOR OFFICE USE ONLY

◯ I have screened this patient for contraindications

◯ Left arm ◯ Right arm

Nurse's Signature: Date:

IRIS	NN	BILLED

LOT #:

Previous Vaccine Received: _____

Date of Most Recent Dose: _____