COVID-19 VACCINE INFORMATION AND CONSENT FORM

Name: _____ _____ _____
First Middle Last

Address: _____ _____ _____ _____
Street City State Zip

Telephone: (_____) _____--_____ _____
Cell: ( ) _____-_____ SSN

Date of Birth:	Age:	**Gender:**	**Primary Language:**	**Ethnicity: (check only 1)**
_____--_____--_____		☐ Male ☐ Female	☐ English ☐ Other _____	☐ Not Hispanic ☐ Hispanic ☐ Unknown

Race: (check only 1) ☐ Asian/Polynesian ☐ Black ☐ Multiracial ☐ White ☐ Native Am/Alaskan ☐ Unknown

☐ Migratory/Seasonal Agricultural Worker ☐ Experiencing Homelessness ☐ Resident of Public Housing

☐ Limited English Proficiency

I have been given a copy and have read, or have had explained to me, the information in the Vaccine Information Statements for the vaccines indicated. I have had the chance to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of the vaccines requested and ask that the vaccines indicated be given to me or the person named for whom I am authorized to make this request.

It is suggested that anyone getting a vaccine stay for 15 minutes after getting vaccinated before leaving. Those with previous anaphylactic reactions should stay for 30 minutes. I hold harmless CCHS should I choose not to wait the recommended time.

_____ _____ **X**_____
Date **Print Name** **Patient/Guardian Signature**

Date of Vaccination: _____

INSURANCE INFORMATION

Insurance Company Name: _____

Insurance ID: _____

Name of Insured: _____ **DOB OF INSURED:** _____

CCHS Staff Use Only

OFFICE USE ONLY	**Record of Immunization**						**OFFICE USE ONLY**
	Vacc						
Manf	**Lot #**	**Exp**	**Dsg**	**Rte**	**Ste**	**VIS**	**Nurse**