ALLCARE MEDICAL

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COVID-19 Vaccine Consent Form

Vaccine Administered: Pfizer [ ] Moderna [ ] Janssen [ ]

Dose #1: [ ] Dose #2: [ ]

Patient Name: _____ DOB: _____

Date: _____

MRN # (Office use only): _____

I have read or had read to me the Vaccination Information Sheet (VIS) or Emergency Use Authorization (EUA) regarding the COVID-19 vaccines. I understand the benefits and risks of the above-mentioned vaccines and request that it be given to me or the person named above for whom I am authorized to make this request.

Ethnicity: Hispanic/Latino ( ) Non-Hispanic/Non-Latino ( ) Unknown ( )

Race: ( ) American Indian/Alaskan Native ( )Black/African American ( ) White ( ) Other ( ) Unknown

Insurance Company If Applicable: _____

Consent

I acknowledge that the vaccine record may be shared with the federal, state or city agencies Vaccine Registry.

I acknowledge that the Medical Providers recommend that vaccinated patients should be monitored for 15 minutes after the vaccine administration.

Signature of person to receive vaccine or authorized person (Parent or Guardian)

X_____ Relationship:_____