ADHS COVID-19 Vaccine Consent Form

ARIZONA DEPARTMENT OF HEALTH SERVICES
PREPAREDNESS

Use this form in conjunction with the CDC Pre-Vaccination Checklist for COVID-19 Vaccines.

(Staff only) Appointment ID: _____

Patient Information

Last Name | First Name | Middle Name (optional)

Mother's Maiden Name (REQUIRED) | Date of Birth (MM/DD/YYYY) | Gender

Address | Apartment Number | City | State | Zip

◯ **No address available**

Phone Number

Email Address

Insurance Information

Do you have insurance? ◯ **Yes** ◯ **No**

Plan Name | Plan Group ID # | Plan Individual ID #

Name of Person Covered By Plan | Plan Responsible Person Name

Private Insurance Address and Phone Number (If Available)

CONSENT AND ASSIGNMENT OF BENEFITS: *I have had a copy of the Emergency Use Authorization for the COVID-19 vaccine made available to me. I have had a chance to ask questions and I believe I understand the benefits and risks of the COVID-19 vaccines requested. I ask that the vaccines be administered to me or the person for whom I am authorized to make this request.*

I certify that I am: (1) the patient and at least 18 years of age; (2) the legal guardian of the patient and the patient's age makes him/her eligible to receive the vaccine based on the current emergency use authorization; or (3) a person authorized to consent on behalf of the patient where the patient is unable to consent for themselves.

I hereby assign to _____ any insurance or other third-party benefits available for the administration fee of the COVID-19 vaccine provided to me. I agree to forward to _____ all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

I agree to allow the health care provider to release information to the Arizona State Immunization Information System (ASIIS) to record that I (or for the person for whom I am authorized to consent) have received this COVID-19 vaccine. This information will help keep track of the manufacturer and doses of the vaccine.

Patient Printed Name | Patient Signature | Date Signed

Parent/Guardian/Authorized Person Printed Name | Authorized Person's Signature | Date Signed

Vaccine Administration Information for Immunizer Use Only

Administration Date | Manufacturer | NDC # | ◯ LEFT ARM | ◯ RIGHT ARM

Lot Number | Expiration Date | Route | Site

Administering Immunizer Name and Title | Administering Immunizer Signature

Is this the patient's first, second, or third dose? ◯ **First** ◯ **Second** ◯ **Third** ◯ **Booster Dose**