

ADHS COVID-19 Vaccine Consent Form

Use this form in conjunction with the [CDC Pre-Vaccination Checklist for COVID-19 Vaccines](#).



ARIZONA DEPARTMENT
OF HEALTH SERVICES
PREPAREDNESS

(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

Insurance Information

Do you have insurance? Yes No

Email Address

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 (ASIS) 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**

Prevaccination Checklist for COVID-19 Vaccination



Name _____

For vaccine recipients (both children and adults):

The following questions will help us determine if there is any reason COVID-19 vaccine cannot be given today.

If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given. It just means additional questions may be asked. If a question is not clear, please ask the healthcare provider to explain it.

	Yes	No	Don't know
1. How old is the person to be vaccinated? _____			
2. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> If yes, which vaccine product was administered? <ul style="list-style-type: none"> <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Janssen (<i>Johnson & Johnson</i>) <input type="checkbox"/> Another Product <input type="checkbox"/> Moderna <input type="checkbox"/> Novavax 			
<ul style="list-style-type: none"> How many doses of COVID-19 vaccine were administered? _____ 			
<ul style="list-style-type: none"> Did you bring the vaccination record card or other documentation? 	<input type="checkbox"/>	<input type="checkbox"/>	
4. Is the person to be vaccinated have a health condition or undergoing treatment that makes them moderately or severely immunocompromised? <i>This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the person to be vaccinated ever had an allergic reaction to: <i>(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)</i>			
<ul style="list-style-type: none"> A component of a COVID-19 vaccine 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> A previous dose of COVID-19 vaccine 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the person to be vaccinated ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? <i>(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Check all that apply to the person to be vaccinated:			
<input type="checkbox"/> Have a history of myocarditis or pericarditis			
<input type="checkbox"/> Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?			
<input type="checkbox"/> History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)			
<input type="checkbox"/> Have a history of thrombosis with thrombocytopenia syndrome (TTS)			
<input type="checkbox"/> Have a history of Guillain-Barré Syndrome (GBS)			
<input type="checkbox"/> Have a history of COVID-19 disease within the past 3 months?			

Form reviewed by _____

Date _____