COVID-19 Vaccine Consent Form

**In order to get your vaccine you MUST attch a photocopy of your insurance card to this paperwork and provide your full social security number!

PERSONAL INFORATINO ABOUT INDIVIDUAL TO RECEIVE VACCINE						
Last Name		First Name		M.I.	Gender (circle) Male Female	
Date of Birth	Age	Social Security #	Telephone Number		Alternate Number	
Address		City	State	County		Zip

PLEASE SELECT ALL THAT APPLY TO INDIVIDUAL GETTING VACCINATION:

Healthcare Worker:
___Inpatient
__Outpatient
__Long term Care Facility
__Home Health/Hospice
__Other HCW:
__Laboratory

__ Emergency Medical Services
__Mortuary Services Provider

First Responder:
__Law Enforcement
__Fire Services
__Correction Officer
__ Other:

__Live or work in congregate or group setting (Group Home, Shelter, Correctional Facility
__*Condition that puts one at high risk of severe illness or death from COVID-19
__Work (paid/unpaid) in a K-12 school -educators, administrators, bus drivers, support staff
__Work in one of the following: Food and Agriculture, Transportation and Logistics, Manufacturing, Public Safety, Food Service, Energy, Water and Waste Management, Legal, Media, Finance, Public Health
__ Age 65 and older
__None of the categories apply to the individual getting vaccinated

*Cancer, Chronic Kidney Disease, COPD, Heart conditions, Immunocompromised, Obesity and Severe Obesity, Pregnancy, Sickle Cell Disease, Smoking, Type 2 Diabetes, Asthma, Cardiovascular Disease, Cystic Fibrosis, High Blood Pressure, Neurologic conditions such as dementia, Liver Disease, Overweight, Pulmonary Fibrosis, Type 1 Diabetes Mellitus

VACCINATION AND HEALTH-RELATED NFORMATION: If you answer Yes to questions 1 - 4, consult a health care provider.	YES	NO
1. Does the patient have long-term health problems with: immunocompromised condition or taking a medicine that affects your immune system; heart disease; lung disease; asthma; kidney or liver disease; metabolic disease such as diabetes; bleeding disorder or take blood thinner		
2. Has the patient had life-threatening reaction to any injectable medication, COVID-19 vaccine, or to a vaccine component (example eggs, thimerosal, gelatin, neomycin, phenol, or bovine protein? Yes, list:		
3. For Women: Are you pregnant or considering becoming pregnant in the next three months or currently nursing? If male, circle: NA		
4. Has the patient had a seizure or any other brain or other nervous system problem (i.e., Guillain-Barre Syndrome) after receiving vaccine?		
Has the patient ever received COVID-19 vaccination? If yes, date given:_____ Manufacturer: Johnson & Johnson		

I have read or have had explained to me the information in the Vaccine Fact Sheet or Vaccine Information Sheet (VIS) about the Vaccine and a EUA Fact Sheet or VIS has been proided to me. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of requested Vaccine and ask that the Vaccine be given to me. I have reviewed the notice of my privacy rights and am aware that Rock Creek Pharmacy has their privacy practices posted in store. I understand that I can request a copy of these practices. I understand my infomation and Vaccine(s) I receive will be entered into the Alabama Department of Public Health Immunization Registry. I give my permission for my insurance company to be billed and authorize payment directly to Rock Creek Pharmacy. I waive and release all claims I, or anyone claiming by or through me, now have or may hereafter acquire against Rock Creek Pharmacy, and their respective owners, officers, employees, and agents for any damager or injuries if I, or the person named above for whom I am authorized to make this request, contract the illness prevented by the Vaccine, other diseases, or suffer any other adverse reactions following administration of this vaccine.

Signature of Individual/Parent/Legal Guardian _____ Date _____

For Clinic Use Only

Clinic Site	Date Vaccine and VIS/Fact Sheet Given		Type and Date of VIS or EUA Fact Sheet				
Rock Creek Pharmacy			Johnson & Johnson				
Vaccine Given	Manufacturer	Lot #	NDC #	Exp. Date	Injection Site	Route	Dose
Johnson & Johnson	Janssen		59676-0580-15		LA RA	IM	0.5 ml
Nurse Signature					Date		

Notes: