



Immunization Clinic Information COVID Consent Form

Office Use Only
K , S , A

Thank you for attending the Weber-Morgan Health Department COVID-19 Immunization Clinic. We appreciate you getting the COVID-19 vaccine as it is important to our community. At this time, we recommend that you follow other safety precautions even after completing the COVID-19 vaccine series.

- Please read the vaccine information statements available in the check-in area or by visiting the links below, we are also happy to provide you your own copy. They will answer questions you may have regarding the vaccine.
 - **Moderna COVID-19 Vaccine:** <https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/spikevax-and-moderna-covid-19-vaccine#additional>
 - **Pfizer-BioNTech COVID-19 Vaccine:** <https://www.fda.gov/media/144414/download>

Please fill out the following information for the person receiving the vaccine.

Legal First and Last Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ ZIP Code: _____ Gender: _____

Telephone #: _____ Cell Phone #: _____ Email: _____

Race: _____ Ethnicity (circle one): **Hispanic Non-Hispanic** Mother's Maiden Name: _____

I have been given a copy and have read, or had explained to me, the information contained in the Vaccine Information Statement for the person receiving the vaccine(s). I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) be given to me or the person for whom I am authorized to make this request. I agree that this information may be shared with schools, daycare centers, healthcare providers and others when medically necessary. I understand that it is my responsibility to know what my insurance plan covers and agree to pay the portion not covered by my insurance. I understand that if Weber-Morgan Health Department does not have a contract with my insurance company, or my insurance company denies payment, I am responsible for all charges incurred. I am hereby notified that the Weber-Morgan Health Department's Notice of Privacy Practices is located on their web site at www.webermorganhealth.org and I have had a chance to ask questions about how my public health information will be used.

1. Have you been ill in the last week with anything more severe than a cold? No Yes

2. Have you had a serious reaction to a previous vaccination? No Yes

3. Have you had a serious allergy to any foods or medications? No Yes

If yes, please list: _____

4. Are you immunocompromised? No Yes

5. (For Females) are you pregnant or breastfeeding? No Yes

6. Which dose is this? (circle one) **1st dose** **2nd dose** **3rd dose (immunocompromised)** **Booster**

7. Which brand would you like to receive? (circle one) **Moderna** **Pfizer**

Parent/Guardian/Client Signature: _____

*** Space below for Office Use Only***

Vaccine Given:	Site:	Date: _____
<input type="checkbox"/> Moderna Bivalent 12+ _____ 0.50 ml	<input type="checkbox"/> L <input type="checkbox"/> R Del/Thigh	Vaccinator's Signature: _____
<input type="checkbox"/> Moderna Bivalent 6-11yr _____ 0.25 ml	<input type="checkbox"/> L <input type="checkbox"/> R Del/Thigh	
<input type="checkbox"/> Moderna Primary 12+ _____ 0.50 ml	<input type="checkbox"/> L <input type="checkbox"/> R Del/Thigh	
<input type="checkbox"/> Moderna Primary 6mo-5yr _____ 0.25 ml	<input type="checkbox"/> L <input type="checkbox"/> R Del/Thigh	
<input type="checkbox"/> Pfizer Bivalent 12+ _____ 0.30 ml	<input type="checkbox"/> L <input type="checkbox"/> R Del/Thigh	
<input type="checkbox"/> Pfizer Bivalent 5-11yr _____ 0.20 ml	<input type="checkbox"/> L <input type="checkbox"/> R Del/Thigh	
<input type="checkbox"/> Pfizer Primary 12+ _____ 0.30 ml	<input type="checkbox"/> L <input type="checkbox"/> R Del/Thigh	
<input type="checkbox"/> Pfizer Primary 5-11yr _____ 0.20 ml	<input type="checkbox"/> L <input type="checkbox"/> R Del/Thigh	

Notes: _____