COVID-19 2023-2024 Vaccine Consent

Cedar County Public Health
400 Cedar St. Tipton, IA

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	GENDER (circle one): Male Female Other

DATE OF BIRTH: ___ ___ / ___ ___ / ___ ___ ___ ___	AGE:	PHONE NUMBER:

STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

Vaccine Brand Requested (Moderna or Pfizer):	Allergies (Please list):

PLEASE ANSWER ALL QUESTIONS	CIRCLE ONE	
1. Have you previously completed your primary COVID-19 vaccination series?	YES	NO
2. Are you sick today? Been diagnosed with COVID-19 in the past 10 days or exposed to someone who has?	YES	NO
3. Have you received tixagevimab/cilgavimab (EVUSHELD) for COVID-19 pre-exposure prophylaxis? (see reverse)	YES	NO
4. Are you allergic to any foods, medications, vaccines, or latex? (For example: polysorbate, stool softeners, etc.?)	YES	NO
5. Have you ever had severe allergic reaction (anaphylaxis) requiring epinephrine, or for which you went to the hospital?	YES	NO
6. Do you have a bleeding disorder or are you taking a blood thinner?	YES	NO
7. If you are receiving this vaccine as a booster, do you meet eligibility criteria (including age and spacing between doses) to receive a **booster**?	YES	NO
8. **Did you experience a severe reaction following a previous dose of COVID-19 vaccine—including myocarditis or pericarditis?**	YES	NO
9. In the past 4 weeks have you received the monkeypox vaccine?	YES	NO

CONSENT FOR VACCINATION

- The Vaccine Information Sheet, or the Emergency use Authorization fact sheet have been made available to me and I understand the risks & benefits. I understand that this vaccine dose is authorized under Emergency use Authorization by the FDA for the prevention of COVID-19. I give consent to Cedar County Public Health to vaccinate the person named above and to record the vaccination in the Iowa Immunization Registry Information System (IRIS).I understand that my information or the person named above for whom I am authorized to make this request, may be disclosed for research or public health purposes as applicable by law.
- I certify that the information I provided for payment is correct. I authorize release of all records required to act on this request. I authorize Medicare, Medicaid, United Healthcare, or Blue Cross Blue Shield to make payments directly to Cedar County Public Health. If payment is denied, I am responsible for the charges.

Patient/Guardian Signature: X _____ **Date:** _____

INSURANCE

INSURANCE COMPANY NAME:	UNINSURED ◯
IDENTIFICATION NUMBER:	GROUP NUMBER:
NAME OF CARD HOLDER:	BIRTH DATE OF CARD HOLDER:

FOR OFFICE USE ONLY

◯ I have screened this patient for contraindications

◯ Left arm ◯ Right arm

Nurse's Signature: Date:

IRIS	NN	BILLED

LOT #:

Previous Vaccine Received: _____

Date of Most Recent Dose: _____

Tixagevimab/Cilgavimab (EVUSHELD) for COVID-19 pre-exposure prophylaxis

- Evusheld may reduce your body's immune response to a COVID-19 vaccine. If you receive a COVID-19 vaccine, you should wait to receive Evusheld until at least two weeks after your COVID-19 vaccination.

Information provided by CDC