Non-MFHC Patient Recipient Personal Information-All Information will be kept confidential

Legal Name: Last Name	First Name:	Middle Initial:
Date of Birth	Parent Full Name & Date of Birth	Email Address

Physical Address:	City	State	Zip	County
Mailing Address:	City	State	Zip	County

If you have Medicaid or private insurance, please provide:

Insurance company Name: _____

Policy Number: _____ Group/ID Number: _____

Phone number:	Preferred Language Spoken:

Gender: □ Male □ Female

Ethnicity: □ Hispanic/Latino □ Not Hispanic/Latino □ I don't care to report

Race (check all that apply):

□ American Indicia/Alaskan Native □ Asian □ Black/African American □ Native Hawaiian

□ Other Pacific Islander □ White/Caucasian □ Decline to report

Informed Consent-COVID-19 Vaccine

Before you receive the Vaccine, please read the Fact Sheet for Recipients and Care Givers and talk to your healthcare provider about any questions or concerns you might have. You have the option to accept or refuse the vaccine.

Please Complete the following:	**Circle One**	
Are you 18 years of age or older?	Y	N
Are you currently sick or running a fever greater than 100.4?	Y	N
Do you have a bleeding disorder or are you on a blood thinner	Y	N
Are you immunocompromised or are you on a medicine that affects your immune system?	Y	N
Have you had a severe allergic reaction to any component of the vaccine?	Y	N
Have you ever had a severe allergic reaction (lightheadedness, recurrent vomiting, etc.) to any medication, vaccine, and/or latex that may have required epinephrine or other emergency intervention?	Y	N
Are you breastfeeding, pregnant, or planning to become pregnant?	Y	N
Have you received any vaccination in the last 14 days?	Y	N
Have you had a confirmed positive case of COVID-19 in the past 90 days?	Y	N
Have you received another COVID-19 vaccine?	Y	N
Do you have any of the following illnesses or conditions? Chronic lung disease (including asthma), heart disease, diabetes, brain, spinal cord, or muscle illness that causes swallowing or lung problems, problems with the immune system caused by medication and/or HIV, kidney disease, blood disorders.	Y	N

Authorization to administer vaccine:
I have answered the above questions truthfully. I have received and understand the vaccine fact sheet including the potential risks and benefits of receiving the vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I hereby release this provider, its employees and its volunteers from any liability for any results which may occur from the administration of this vaccine.

_____ _____
Recipient Name (Print) Date of Birth:

_____ _____
Parent/Guardian/Caregiver Name (if different than recipient) Relationship to recipient

_____ _____
Signature Date

DO NOT WRITE BELOW THIS LINE

For Mountain Family Health Provider use only:

Initial Dose:	Date:	**Booster Dose:**	Date:
Manufacturer/NDC		MRN:	
Lot#: _____ Site: RUA LUA	Exp: _____ Route: IM	Lot#: _____ Site: RUA LUA	Exp: _____ Route: IM
Vaccine given by:		Vaccine given by:	