LOVELACE FAMILY MEDICINE COVID-19 VACCINE CONSENT FORM

A NEW FORM MUST BE COMPLETED FOR EACH DOSE

FIRST NAME: (name must match insurance card)	**MIDDLE NAME/INITIAL:**	**LAST NAME:** (name must match insurance card)	**AGE**
DATE OF BIRTH:	GENDER	RACE/ETHNICITY:	
SOCIAL SECURITY #	ADDRESS		
CITY	COUNTY	STATE	ZIPCODE
PHONE	EMAIL		
INSURANCE COMPANY	POLICY # / MEMBER ID	NO INSURANCE	
GUARANTOR / POLICY HOLDER'S NAME	GUARANTOR / POLICY HOLDER'S DATE OF BIRTH		

Question	Answer
DO YOU HAVE A FEVER? ARE YOU FEELING SICK TODAY?	**YES / NO**
HAVE YOU EVER HAD AN ALLERGIC REACTION THAT REQUIRED TREATMENT WITH AN EPIPEN OR THAT CAUSED YOU TO GO TO THE HOSPITAL?	**YES / NO**
Do you have a history of allergic reaction or allergies medications, food or vaccines?	**YES / NO**
Do you have a history of MIS-C or MIS-A (multisystem inflammatory syndrome in children or multisystem inflammatory syndrome in adults)?	**YES / NO**

By signing below, you acknowledge the following:
Information about the vaccine has been made available to you. The vaccine being administered to you is not guaranteed to keep you from getting COVID-19. You may experience an adverse, even unexpected, reaction to it, including, without limitation, all or some of the signs and symptoms listed on the Vaccine Information Sheet. You are making an informed decision to receive the vaccine. You fully release and discharge Lovelace Family Medicine, its affiliates and assigns, and its officers, and employees from any illness, injury, loss, or damage that may result from the administration of the vaccine. You also agree to wait in the vaccination area for 15-30 minutes for monitoring and to receive treatment in case of adverse reactions. Your insurance company will be billed for the administration of the vaccine and any additional services provided in the event of an adverse reaction. Should you experience any symptoms, such as, without limitation, a fever of more than 101.5 F, fatigue, chills, headache, myalgia, or pain at the injection site, please contact your healthcare provider as soon as possible. If it is an emergency, please go to your nearest emergency medical provider if it can be done safely or contact 9-1-1.

I acknowledge that I have had an opportunity to read, understand and ask questions about the vaccine and the COVID-19 Vaccine Fact Sheets/VIS relating to the vaccine I will be receiving and I accept all risks associated with such. I authorize Lovelace Family Medicine to release all information necessary to process my claims and provide the services above.

RECIPIENT SIGNATURE:	DATE:
PARENT/GUARDIAN SIGNATURE: (if recipient is under 16 years of age)	PARENT/GUARDIAN PRINTED NAME: (if recipient is <16 yrs o

FOR STAFF USE ONLY	
Date of Service:	**VACCINE INFO STICKER**

91322 - Moderna COVID-19 Vaccine 2023-2024 Formula 50mcg/0.5ml prefilled syringe NDC: 80777-0102-01

Site: LEFT / RIGHT DELTOID / THIGH Monitor for: 15 minutes / 30 minutes

Administered by: ___________________ Documented by: ___________________ Scanned by: ___________________