COVID Vaccine Consent Form

☐Cy's ☐Sinclair ☐Tile ☐Wanakah ☐Kenmore ☐Family Medical ☐Larwood ☐Alden

Print Carefully:

Last Name	First Name	M/I	Birth Date	Age	M/F

Street Address	City	Zip Code	Phone Number

Screening:

Yes	No	
☐	☐	Has it been at least 2 months since your last COVID vaccine?
☐	☐	Have you had any vaccines in the last 14 days?
☐	☐	Do you have any allergies to vaccines or vaccine components?
☐	☐	Have you ever had a severe or immediate allergic reaction to a vaccine or vaccine component?
☐	☐	Do you feel sick today?
☐	☐	Do you have a fever?
☐	☐	Do you have a weakened immune system?
☐	☐	Do you have a bleeding disorder or take a blood thinner?
☐	☐	Do you have a history of myocarditis or pericarditis?

Consent:
By signing below, I attest that I have received the COVID Vaccine Sheet (VIS) and have had the opportunity to ask questions. I understand the benefits and risks associated with receiving a vaccination. I request that the vaccine be administered to me, and it is recommended that I remain in the healthcare facility for 15 minutes after the vaccine. I authorize the pharmacy to notify my primary health care physician of the receipt.

☐By checking this box, I authorize the pharmacy to upload my immunization to NYSIIS (NYS Vaccine database)

Signature of Recipient_____ Date_____

Vaccination Name:_____ Manufacturer:_____

Lot:_____ Site: LD/RD Administered by:_____

Date:____/____/_____ Time: ___:___AM/PM Signature:_____

Date Modified: 09/20/2023