COVID-19 Vaccination Consent Form

I have received a copy of the Emergency Use Authorization (EUA) fact sheet prior to receiving my immunization and have had an opportunity to ask questions. I understand the benefits and risks of the COVID-19 vaccine as described. I request that the vaccine be given to me or to the person named below for whom I am authorized to sign. I understand that RiverStone Health will provide documentation of my vaccination to the Montana State Immunization Registry called imMTrax.

Name (please print) Birth Date Age

Address City State Zip

Signature of person to receive vaccine (Parent or guardian if under the age of 18) Date

Phone number (_____) _____-_____

Do you have allergies? **___ Yes ___ No**

If so, what are you allergic to? _____

Have you ever had a serious reaction after receiving a vaccination? **___ Yes ___ No**

Ethnicity ____ Not Hispanic or Latino ____ Hispanic or Latino

Race ____Amer Ind/AK Native ____Asian ____ Native HI/other PI
____ Black/Afr Amer ____ White ____Unknown
____Other

Vaccine information

Name/Manufacturer/Lot number _____
Body Site ____ Right Deltoid ___Left Deltoid

Staff signature _____
Date_____