COVID-19 Vaccination Consent Form

I have received a copy of the Emergency Use Authorization (EUA) and /or applicable Vaccine Information 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**

3rd Vaccine / Pfizer Booster Vaccine

I am getting my 3rd (third) COVID-19 vaccination due to being immunocompromised and it has been 28 days since my 2nd COVID-19 vaccination **____Yes ___No**

I am between 18 and 64 years old and have an underlying health condition. Additionally, it has been 6 months since I received my 2nd COVID-19 vaccination. **___Yes ___No**

I am between 18 and 64 years old and at an increased risk for COVID-19 exposure and transmission because of my occupational or institutional setting. Additionally, it has been at least 6 months since I received my 2nd COVID -19 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 - To be filled out by Staff:

Name/Manufacturer/Lot number _____

Body Site **____ Right Deltoid** **___Left Deltoid**

Staff signature _____Date_____