



COVID-19 Vaccination Consent Form 12-17 Years Old

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

Ethnicity _____ Not Hispanic or Latino _____ Hispanic or Latino

Race _____ American Indian/AK Native _____ Asian _____ Native HI/Pacific Islander

_____ Black/African American _____ White _____ Unknown _____ Other

3rd Dose Vaccine or Booster Vaccine (SELECT **ONLY ONE** RESPONSE BELOW)

I am getting my 3rd COVID-19 vaccination (Moderna or Pfizer) because I am *moderately or severely* immunocompromised (active cancer treatment, transplant recipient, advanced HIV, take immune-suppressant medications, etc.) and it has been 28 days since my 2nd COVID-19 vaccination. Ask your healthcare provider if you are uncertain if you meet these criteria. _____ Yes ___ No

I am 18 years or older and it has been at least two months since I received my J&J vaccination or it has been at least 6 months since I received my 2nd COVID-19 Vaccination (Moderna or Pfizer). _____ Yes ___ No

I am 16-17 years of age and it has been at least 6 month since I received my 2nd COVID-19 Pfizer Vaccination. _____ Yes ___ No

Vaccine information - To be completed by Staff:

Name/Manufacturer/Lot number _____

Pfizer 1st Dose _____ 2nd Dose _____ 3rd Dose _____ *Booster _____ (16-17 Years Only)

Body Site _____ Right Deltoid _____ Left Deltoid

Staff signature _____ Date _____