



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 imMTIax.

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 2 months since I received my 1st J&J or 5 months since I received my 2nd Pfizer or Moderna COVID-19 Vaccination.

_____ Yes _____ No

I am getting my 2nd COVID-19 booster (Moderna or Pfizer) because I am over 50 years of age or *moderately or severely immunocompromised* (active cancer treatment, transplant recipient, advanced HIV, take immune-suppressant medications, etc.) and it has been at least 4 months since my 1st COVID-19 booster.

_____ Yes _____ No

Vaccine information - To be completed by Staff:

Name/Manufacturer/Lot number _____

Pfizer 1st Dose _____ 2nd Dose _____ 3rd Dose _____ Booster _____

Moderna 1st Dose _____ 2nd Dose _____ 3rd Dose _____ Booster _____

Body Site _____ Right Deltoid _____ Left Deltoid

Staff signature _____

Date _____