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**

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** _____

Novavax **1st Dose** _____ **2nd Dose** _____

Body Site ____ **Right Deltoid** ___**Left Deltoid**

Staff signature _____ **Date**_____