



2020-2021 COVID-19 VACCINE CONSENT INACTIVATED INJECTABLE COVID-19 VACCINE

Name of Individual to be Immunized (please print)		Birth Date	
Address	City	State	Zip Code
Phone (cell preferred)	Email		
Employer	Phone		
Position	Staff Use Only Verified Tier:		

Please answer the following questions:

- Have you received passive antibody therapy as treatment for Covid-19? Yes No
- Have you ever had a severe allergic reaction after receiving a vaccine? Yes No
- Do you have a bleeding disorder or are you taking blood thinners? Yes No
- Have you received any Covid vaccination in the past 4 weeks? Yes No
- Females only: Are you pregnant or plan to conceive within the next 2 months? Yes No

Acknowledgement:

1. I am at least 18 years of age. I have read or have had explained to me the Covid-19 vaccine including the emergency usage vaccine information sheet. I have been given the opportunity to ask health care professionals concerning the vaccine and its risks and benefits. All my questions concerning the vaccine have been answered to my satisfaction.
2. I understand the benefits and risks of the Covid-19 vaccine and request that it be given to me.
3. I understand my medical care provider will submit this immunization information to the state immunization registry. Privacy notice available upon request.

Release of Liability:

I have read and I understand the acknowledgements set forth above, and I hereby release Elko County and NNRH, and all their agents, employees, trustees, and representatives, from all liability which may arise from the vaccination and/or from the information provided to me concerning such vaccination.

Consent to the Vaccination:

I have read and I understand the information set forth in this form. Based on that understanding, I hereby CONSENT to receive a Covid-19 vaccination.

Signature of Recipient of the Vaccination

Date

If signed by someone other than recipient, please indicate name and relationship

DO NOT WRITE BELOW THIS LINE

Administered by

Print Name

For Office Use Only

(Check Appropriate Box): Pfizer Moderna

Covid-19 Vaccine Lot #: _____ Exp: _____ Date: _____

Site of Injection: R L Deltoid Return for Dose #2 on: _____