Consent for COVID-19 Vaccination

Indiana Department of Health

Complete the following for the person who is being vaccinated:

Name: FIRST _____MIDDLE_____ LAST _____

Phone: ( ) - Birth Date: / / Age: Sex: ☐F ☐M

Mailing Address: _____ City: _____ State: _____ZIP: _____

Parent/Guardian Full Name: _____ Parent Cell Phone # _____

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

Race: (Check all that apply) ☐ American Indian/Alaskan Native ☐Asian ☐Black ☐Native Hawaiian/Pacific Islander ☐White ☐Unknown

Questions for the person getting vaccinated:	**NO**	**YES**
1. Is the person to be vaccinated sick today? If yes, what are their symptoms?	☐	☐, symptoms: _____
2. Does the person to be vaccinated have any allergies to medications, foods, a vaccine component, or latex? Please list allergies:	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to a vaccine in the past? If yes, please explain:	☐	☐
4. Has the person to be vaccinated ever had Guillian-Barre Syndrome (GBS)?	☐	☐
5. Does the person to be vaccinated have a long-term health problem related to heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐
6. Does the person to be vaccinated have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐
7. During the past year, did the person to be vaccinated take cortisone, prednisone, other steroids, or anticancer drugs, or receive X-ray treatments for cancer?	☐	☐
8. Does the person to be vaccinated have a seizure, brain or other nervous system disorder?	☐	☐
9. Does the person to be vaccinated smoke?	☐	☐
10. During the past year, has the person to be vaccinated received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	☐	☐
11. For women: Is the person to be vaccinated pregnant or is there a chance they could become pregnant during the next month?	☐	☐
12. Has the person to be vaccinated received any vaccinations in the past 2 weeks?	☐	☐

By signing below, I consent to the use and disclosure of my or my child's personal health information for the purpose of health care operations, along with the assignment of all payments from the insurer listed above to Indiana Department of Health (IDOH) for the services rendered.

Consent for use of protected health information & claims assignment: I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payment from the insurance provider (if applicable) to IDOH for administration of the COVID - 19 vaccination.

Vaccine authorization: My signature on this form indicates that I have requested that the COVID-19 vaccine be administered to me or my dependent by a vaccination clinic representative. I relieve the vaccination site and staff of any liability for any reactions that should occur. I unconditionally and irrevocably waive any right to a trial by jury, to the maximum extent allowed by law, for any claim or action arising out of or related to this service, and that any such claim or action shall be determined solely on an individual.

Signature of Parent or Guardian_____ Date:_____

If student under 18 years of age