NORTHWEST Kidney Centers

COVID-19 Vaccine Consent Form

NAME (Legal Last, Legal First) _____

PLEASE Print

DATE OF BIRTH MM_____DD_____YYYY_____

Screening Questions for COVID 19 Vaccination:

1. Are you feeling ill today? ◯ Yes ◯ No
2. Have you had a severe allergic reaction (e.g., anaphylaxis) to a previous COVID-19 vaccination or component of COVID-19 vaccine? ◯ Yes ◯ No

Acknowledgements:

I made the choice to get the COVID-19 vaccine on my own and freely. I know I have the option to refuse the vaccine. I ask that the vaccine be given to me, or to the person named above for whom I can make this request. I was given the (Fact Sheet for Vaccine Recipients and Caregivers) for this vaccine. The fact sheet has information about side effects and adverse reactions. I read or had read to me the information provided about the COVID- 19 vaccine.

I know that if I have a severe allergic reaction, including difficulty breathing, swelling of my face and/or throat, a fast heartbeat, a bad rash all over my body or dizziness and weakness I should call 9-1-1 or go to the nearest hospital. I know I can call my health care provider if I have any side effects that bother me or do not go away.

Disclosure of Records: I understand Northwest Kidney Centers may be required to or may voluntarily disclose my vaccine-related health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, payment, or health care operations. I also understand Northwest Kidney Centers will use and disclose my health information as described in its Notice of Privacy Practices.

By signing this consent, I certify that (i) I am the individual completing the form; (ii) all information entered on this form is true and accurate to the best of my knowledge; (iii) I have been provided the fact sheet for the vaccine I am to receive and have read or had it read to me. I have had the opportunity to ask questions and understand the risks and benefits; and (iv) By signing below, I consent to receive the COVID-19 vaccine.

_____

PRINT NAME OF PATIENT

_____

PRINT NAME OF LEGAL REPRESENTATIVE (IF APPLICABLE)

_____

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE

DATE MM____DD____YYYY_____ **TIME _____:_____AM/PM**

◯ I have reviewed the screening and exclusion criteria with the patient. I have determined that the criteria for vaccination has been met and no contraindications exist. **OR**

◯ I have reviewed the screening and exclusion criteria with the patient. I have determined that they **DO NOT** meet the criteria for receiving the vaccine and/or the vaccine is contraindicated.

VACCINATOR SIGNATURE_____ _____ **SITE** ◯ Left Deltoid ◯ Right Deltoid

SERIES ◯ **Manufacturer:** Moderna **(2024–2025 Formula)** COVID-19 Vaccine 50mcg/0.5mL **NDC:** 80777-0102-93
Brand: Spikevax

VACCINATION CLINIC LOCATION:

PLACE LOT STICKER HERE

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