Advanced Care Rx

500 N Cass St

Berrien Springs, MI 49103

(269)815-5418

Vaccination Consent Form

Full Name (Please Print) ______________________________ Date of Birth___________

Male Female

Address ______________________________ City _________________ State __________ Zip______

Email____________________ Phone Number _________________

Primary Care Provider _______________

Screening for Vaccination Eligibility

Are you pregnant?	Yes	No
Are you currently breastfeeding?	Yes	No
Have you had a severe allergic reaction (anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause?	Yes	No
Do you feel sick today?	Yes	No
Have you received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next 14 days	Yes	No
Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?	Yes	No
Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No
Have you tested positive for COVID-19 in the last 10 days?	Yes	No
Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had X-ray treatments recently?	Yes	No

Consent for Vaccination

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization Fact Sheet provided to me today. I understand the benefits and risks of the vaccine.

The vaccine checked above should be given to the person named above for whom I am authorized to make this request. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

Signature of Parent/Guardian/Patient ________________________________ Date ___________

For Administrative Use Only VIS Date:

Vaccine	Date Given	Route	Manufacturer	Lot No	Printed Name and Signature of vaccine Administrator