

COVID-19 VACCINE BOOSTER CONSENT FORM

Person Receiving Vaccination

Name: _____

Date of Birth: ____/____/____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

IMPORTANT: TO HAVE YOUR SHOT REPORTED TO THE ARKANSAS VACCINE DATABASE WE MUST FILE IT THROUGH THE STATE USING EITHER YOUR DRIVERS LICENSE NUMBER, SOCIAL SECURITY NUMBER OR PASSPORT NUMBER. * If you are not registered under any of these identifiers, please circle N/A. No further questions will be asked

SSN: ____-____-____ DLN: _____

PASSPORT NUMBER: _____ N/A

PLEASE ANSWER THE FOLLOWING QUESTIONS	*YES	NO
Please circle which vaccine series you received. PFIZER MODERNA		
Have you had any vaccines within the previous 14 days? Pfizer-BioNtech COVID-19 vaccine should be administered alone with a minimal interval of 14 days before or after any other vaccine.		
Do you have a fever today? Are you sick today? Do you have COVID-19 infection and currently in isolation? Are you currently in quarantine for known exposure to Covid-19?		
Have you received monoclonal antibodies of convalescent plasma as part of COVID-19 treatment? Vaccination should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune response.		
Are you pregnant, breastfeeding or planning to become pregnant? Women in this group should receive the COVID-19 vaccine. A Discussion with your health care provider can help make an informed decision.		
List your immunocompromised state on the line provided : _____		

Release and Assignment

My signature below indicates I have agreed to receive the COVID-19 booster and understand all risks associated.

Signature of Patient/Parent/Guardian: _____

Date: _____

