HUMBOLDT COUNTY MEMORIAL HOSPITAL

1st Dose COVID-19 Vaccine Consent Form

Vaccine Recipient Information

Recipient Name: _____
Last First M.I.

Address: _____
Street City State Postal Code

Date of Birth:_____Age:_____ Gender: Male Female

Cell Phone Number: _____

*If Applicable:
Authorized Power of Attorney/Legal Guardian: _____
Name Phone Number

Vaccine Information

Have you received any other vaccine in the last 14 days? YES NO

*If YES, please list vaccine and date received: _____

Have you had COVID-19? YES NO Date Diagnosed: _____

*If YES, did you receive any treatment or medications for COVID-19? _____

Are you currently having any symptoms associated with COVID-19? YES NO

Consent

I have read or have had explained to me the information provided in the Emergency Use Authorization (EUA) Factsheet or Vaccine Information Statement about COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be administered to me or to the person named above for whom I am authorized to make this request.

Signature:_____ Date: _____

Healthcare Provider Use Only

PRIME DOSE

Date Vaccine Administered:_____ Injection Site (Deltoid): ☐Left ☐Right

Manufacturer:_____ Lot Number:_____Exp: _____

Administered by Print:_____ Signature:_____

☐Vaccine recipient confirmed their name and date of birth and it was verified with the information above.

☐COVID-19 Vaccine EUA FACT SHEET for Recipients was reviewed and provided.

☐COVID-19 Vaccine entered in IRIS