Gibson Area Hospital & Health Services
GIBSON GETS IT

COVID-19 Vaccine Consent Form

Consent to Receive the COVID-19 Vaccine

I have been provided with the vaccine information sheet(s) corresponding to the COVID-19 vaccine I am receiving. I have read or have had explained to me the vaccine information and have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named below for whom I am authorized to make this request. I understand GAHHS may be required to or may voluntarily disclose my health information to my primary care physician, my insurance plan, and/or state or federal registries for purposes of treatment, payment or other health care operations. I also understand that GAHHS does not discriminate in the distriburtion of the vaccine, or otherwise, on the basis of race, color, religion, gender, age, national origin, ethnicity, disability, marital status, sexual orientation or military status. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless GAHHS, its staff, agents, successors, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above. I acknowledge that my health insurance will be billed for the administration of the Covid-19 vaccine. Vaccine recipients incur no charge for receiving the COVID-19 vaccines.

Patient Name (Please Print)	**Date of Birth**	**Ethnicity/Race**
Home Address		**Age**
Street, City/State, Zip		**Patient Phone #**
Signature of Person Receiving Vaccine (or parent/guardian)		**Date**

Are you feeling well today? Y N	**Have you received any other vaccines in the past 14 days? Y N**
Have you received any COVID-19 treatments in the past 90 days? Y N	**Have you EVER had an anaphylactic reaction to ANY vaccines? Y N**
Are you pregnant or breastfeeding? Y N	**Are you immunocompromised or taking biologic therapies Y N**
Guarantor Name (If under 18 or other than patient)	**Guarantor DOB**
Guarantor Address. City, State, Zip	**Guarantor Phone #**
Insurance Subscriber Name & Relationship to Patient	**Insurance Subscriber DOB**
Insurance Subscriber Address	**Insurance Subscriber Employer**

For Clinic/Office Use Only- Vaccine Administration Records

Manufacturer:_____ **Lot #:**_____ **NDC #** _____**Exp.Date:**_____

Route: *IM* **Site:** (circle one) *Right Deltoid* *Left Deltoid* *Other*_____

Administered By:_____