Wayne Memorial Community Health Centers

COVID 19 VACCINE AUTHORIZATION 2020/2021

NAME: _____ Date of Birth: _____ Sex: M____ F ____
Print-Last name/First name

Address: _____
Street, City, State, Zip

Phone Number: _____ School: _____

Insurance Company Name: _____ ID# _____

WMCHC along with the Center for Disease Control & Department of Health recommends persons aged ≥ 12 years receive the COVID vaccination for the prevention of COVID-19, for their personal protection as well as for the protection of their families.

Are you currently ill or have a fever greater than 100.5? ☐ **Yes** ☐ **No**
Have you been diagnosed and treated for COVID in the last 90 days? **Yes** **No**
Have you ever had an allergic reaction to any Vaccine or injectable medication? **Yes** **No**

Ethnicity: ____ Choose not to disclose Hispanic or Latino ____ Yes ____ No
Race: _____ Choose not to disclose
_____ Asian
_____Native Hawaiian
_____Other Pacific Islander
_____ Black/African American
_____ American Indian/Alaskan Native
_____ White/Caucasian
_____ More than one race

Vaccine: Pfizer COVID -19 NDC #

Route IM Site: RD LD Immunizer: _____ Date: _____

COVID 19 VACCINES: This vaccine includes a short segment of messenger ribonucleic acid (mRNA). The mRNA is a genetic code that tells cells how to make a protein. It is intended to boost the immune system to produce enough antibodies against SARS-CoV-2; so, in case of an exposure, the virus does not cause illness.

I have reviewed the COVID Vaccine Statement provided and understand the benefits and risks of this vaccine. I **consent** for the COVID vaccine to be administered to me.

I undersigned, hereby CONSENT TO TREATMENT and grant permission to release my medical information and to authorize payment of health insurance benefits to Wayne Memorial Community Health Centers.

Signature: _____ Date: _____
(Patient or Legal Guardian if patient is minor)

If minor child- Name of Parent or Guardian: _____

Relationship to the Patient: _____