COVID-19 Vaccination Consent Form

SECTION A *Please print clearly BELOW.*

First name: M.I.: Last Name:	Home address: (Including City, State and ZIP)	
Date of birth: Gender: ☐ Female ☐ Male ☐ Non-Binary/Other	Phone Number: SSN:	
Authorized Power of Attorney (POA) /Legal Guardian Name: First name: M.I.: Last name:	**Prescriber/Medical Director's Name:** First name: M.I.: Last name:	
City State Zip	Facility Name:	☐ Resident ☐ Staff ☐ Other

SECTION B ***Please choose <u>one</u> of the following:***

<u>Unvaccinated</u>

☐ **1st Bi-Valent Dose**

<u>Previously Vaccinated</u>

☐ **1st Bi-Valent Booster Dose (2 months after Mono-Valent Primary Dose[s])**

☐ **2nd Bi-Valent Booster Dose (65 years & older) (4 months after 1st Bi-Valent Dose)**

☐ **2nd Bi-Valent Booster Dose (immunocompromised) (2 months after 1st Bi-Valent Dose)**

By signing below, I certify that I am: (a) the patient and at least 18 years of age, or (b) the legal representative of the patient, or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or is unable to consent for themselves. I give my consent to the Pharmacy and the licensed healthcare professional administering the vaccine, as applicable (each a "**Provider**"), to administer a COVID-19 vaccine. I understand that it is not possible to predict all possible side effects or complications associated with receiving the COVID-19 vaccine. I understand the risks and benefits associated with the COVID-19 vaccine and have received, read and/or had explained to me the Vaccine Information Statement and/or the Emergency Use Authorization data sheet. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Facility, Pharmacy, and Provider, and their staff, agents, successors, divisions, affiliates, subsidiaries, 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 COVID-19 Vaccine.

SECTION C *Authorization to Request Payment*

I do herby authorize ICP, Inc to release information and request payment. I certify that the information given by me in applying for payment under Medicare, Medicaid, or commercial insurance is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

SECTION D *Disclosure of Records*

I understand that ICP, Inc. may be required to or may voluntarily disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at ICP, Inc. (if applicable), my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries, for purposes of treatment, payment or other health care operations (such as administration or quality assurance). I also understand that ICP, Inc. will use and disclose my health information as set forth in the ICP, Inc. Notice of Privacy Practices (copy is available online or by requesting a paper copy from ICP, Inc.). Vaccine Clinics: If I am receiving a vaccine through a vaccine clinic, I understand that my name, vaccine appointment date and time will be provided to the clinic coordinator.

Signature OR Signature/Printed Name of Health POA OR Name of Health POA/verbally acknowledge by licensed staff (sign & print name & credentials)

Signature Printed Name Date