FORM MUST BE COMPLETED IN FULL BY A PARENT OR GUARDIAN

Consent for COVID-19 Vaccination

Indiana Department of Health

Complete the following for the person who is being vaccinated:

Name: FIRST _____ MIDDLE _____ LAST _____

Phone: (__) _____ Birth Date: __/__/____ Age: _____ Sex: ☐F ☐M

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Parent/Guardian Full Name: _____ Parent Cell Phone# _____

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino

Race: (Check all that apply) ☐American Indian/Alaskan Native ☐Asian ☐Black ☐Native Hawaiian/Pacific Islander ☐White ☐Unknown

Insurance Status (Check box)

☐ NO INSURANCE

☐ MEDICAID

Company: _____ Medicaid #: _____ ☐Don't know

☐ PRIVATE or COMMERCIAL INSURANCE (NOT MEDICAID)

Insurance Company: _____ Insurance Policy ID: _____

Group # _____ (If one applies) Policy Holder Name: _____

Policy Holder Birth Date: ____/____/____ SSN: _____

Policy Holder Relationship to Patient: _____

Questions for the person getting vaccinated:	NO	YES
1. Is the person to be vaccinated sick today? If yes, what are their symptoms?	☐	☐, symptoms: _____
2. Does the person to be vaccinated have any allergies to medications, foods, a vaccine component, or latex?	☐	☐, allergies: _____
3. Has the person to be vaccinated ever had a serious reaction to a vaccine in the past? If yes, please explain:	☐	☐, explain: _____
4. Has the person to be vaccinated ever had Guillain-Barre Syndrome (GBS)?	☐	☐
5. For women: Is the person to be vaccinated pregnant or is there a chance they could be pregnant?	☐	☐
6. Has the person to be vaccinated received any vaccinations in the past 2 weeks?	☐	☐

By signing below, I consent to the use and disclosure of my or my child's personal health information for the purpose of health care operations, along with the assignment of all payments from the insurer listed above to Indiana Department of Health (IDOH) for the services rendered.

Consent for use of protected health information & claims assignment: I hereby consent to and acknowledge the receipt of a Notice of Privacy Practices regarding the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payment from the insurance provider (if applicable) to IDOH for administration of the COVID - 19 vaccination.

Vaccine authorization: My signature on this form indicates that I have requested that the COVID-19 vaccine be administered to me or my dependent by a vaccination clinic representative. I acknowledge that I have received information concerning the risks and benefits of the COVID – 19 vaccine and that I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the risks and benefits of the COVID – 19 vaccine and consent to the administration of the vaccine to me or my dependent.

Signature of Parent or Guardian _____ Date: _____
If student under 18 years of age

Vaccine	Expiration Date	Dosage
Lot Number	Administration Site	Administering Facility/Vaccinator: PCHD/
Manufacturer	Administration Route: IM	Administration Date
VIS/EUA	Second Dose Date/Time	Second Dose Location