COVID VACCINE CONSENT FORM

Last Name _____ First Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____Phone # _____ Sex: Male Female Are you pregnant? Yes No

Not all individuals requesting the vaccine can safely be immunized. Consult with your pharmacist or physician regarding vaccination if one or more of the following is true:

1. Are you allergic to any medication? ☐ Yes ☐ No
2. Are you allergic to Latex? ☐ Yes ☐ No
3. Have you ever had a severe reaction to a vaccine or injected medication? ☐ Yes ☐ No
4. Are you sick or recently recovered from COVID-19 disease? ☐ Yes ☐ No
5. Have you received any vaccinations in the last 14 days? ☐ Yes ☐ No

Having received an explanation and informed consent, I hereby agree to release and hold Hemmingsen Drugstore, its employees, agents and representatives harmless from further responsibility with regard to my receiving the injections.

If you should have a reaction, you should CONTACT YOUR PHYSICIAN, and Hemmingsen Drugstore pharmacist at (269) 781-3411.

I have received and read the VACCINE FACT SHEET, as well as the above information, and have had the opportunity to ask questions. I understand the benefits and risks of the vaccine as described. I request the vaccine to be administered to me or to the person named for whom I am authorized to sign.

_____ _____

Signature: Patient or Authorized Representative Date

☐ Verbal consent for vaccination of individual named or legal guardian for persons under the age of eighteen (18)?

☐ Vaccine Fact Sheet Given

☐ V-Safe Info given

Vaccine product & Lot # _____ Expiration Date _____

Sight of injection: ☐ Right Deltoid ☐ Left Deltoid Clinic:Hemmingsen Drugstore

Administrator Signature and Date _____

☐ Staff member entering into to MCIR