<u>CONSENT FOR COVID-19 VACCINATION <18 years</u>

Complete the following for the person who is being vaccinated:

Name: First ________________ Middle ______________ Last_________________ DOB: ____________
Sex: M/F (Circle) Mailing Address: ____
Parents/Guardian Full Name: __________________________ Phone Number:_______________
Ethnicity: Hispanic/Non-Hispanic (circle)
Race: American Indiana/ Alaskan Native, Asian, Black, Native Hawaiian/Pacific Islander, White, Unknown (circle all that apply)
Insurance Status:

□ No insurance □ Medicaid (please provide RID number) ______________________________
□ Private or commercial Insurance (Not Medicaid)
Insurance Company_________________ Insurance Policy ID ______________
Group # ____________________ Policy Holders name: ________________
Policy Holders DOB: ___________________Policy Holders relationship to patient: _______________

Questions for person getting vaccinated:

Questions	Yes or no	If yes, explain
Is the person to be vaccinated sick today?		
Does the person being vaccinated have any allergies to medications foods, a vaccine component or latex?		
Has the person to be vaccinated ever had a serious reaction to a vaccine in the past?		
Has the person being vaccinated ever had Guillain-Barre Syndrome		
If the person to be vaccinated pregnant or is there a chance they could become pregnant?		

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 and 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 for 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 (you can call 812-481-7056 with questions). 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: __________________

A COPY OF A PARENT'S ID AND INSURANCE CARD MUST BE PROVIDED