ADIRONDACK HEALTH & WELLNESS

2025 COVID MONOVALENT VACCINATION CONSENT FORM

PATIENT INFORMATION

All information is required

Legal First Name		**Last Name**		
Date of Birth	**Sex**	**Mother's Maiden Name**		
Address	**City**	**County**	**State**	**Zip**
Phone		**Email Address**		
Primary Insurance Company		**Insurance ID # or Member #**		
Insurance Policy Holder & Name / DOB:		**Secondary Insurance Name & Member #**		

****Please note if your insurance is denied for any reason, it is the responsibility of the recipient to pay the fee****

Please complete the questions below for yourself or the person receiving the vaccination

Are you feeling sick today?	☐ No	☐ Yes
Have you had COVID-19 in the past 3 months, have you received an infusion?	☐ No	☐ Yes
Have you had COVID-19 VACCINE in the past 2 MONTHS?	☐ No	☐ Yes
Have you ever received a dose of the COVID-19 vaccine?	☐ No	☐ Yes
Have you ever had an allergic reaction to another vaccine or injectable medication?	☐ No	☐ Yes
Have you received any other vaccine in the last 4 weeks?	☐ No	☐ Yes
Are you currently on a high dose of steroids?	☐ No	☐ Yes
Do you have a history of Guillain-Barre Syndrome? (Illness associated with the swine flu in 1976)	☐ No	☐ Yes
If you are female, are you pregnant?	☐ No	☐ Yes
Have you taken an antiviral medication within the last 48 hours?	☐ No	☐ Yes
Do you have a bleeding disorder or are you taking a blood thinner?	☐ No	☐ Yes

PLEASE SIGN BELOW

COVID-19 Consent

I have read, or had explained to me, the Vaccination Information Statement about *COVID-19* vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the *COVID-19* vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.

X_____

Signature of Recipient (Parent or Guardian) Date

TO BE COMPLETED BY NURSE:

Date of Last Covid Vaccine (2 months or greater)

_____

2025 Date: _____

Administration Site:

2025 Monovalent Booster: ☐ **Left Deltoid** ☐ **Right Deltoid**

Moderna (SPIKEVAX)

Booster: 0.5 ml

Manufacturer: _____
Lot Number: _____
Expiration Date: _____

Nurse Signature Booster: _____

****2025 Covid BOOSTER****