2026-A Dabney Rd Richmond, VA 23230
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COVID-19 Vaccination Consent Form

Last Name	First Name	MI	Date of Birth	Gender Male ☐ Female ☐
Street Address	City	State	Zip	
Race	Ethnicity Hispanic ☐ Non-Hispanic ☐	Height	Weight	
Phone Number	Email	Primary Care Provider		
Social Security Number	Driver's License #	DL Issuing State – Expiration Date		
State Medicaid Member #:	Medicare ID # (HIC)			
Medical Insurance Company	Member ID #	Group #		
Prescription Drug Coverage Company	RX ID #	RX Bin #	RX PCN #	RX Group #

	YES	NO	N/A
Are you currently sick? Experiencing chills, fever, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches?			
Have you had a severe allergic reaction (ie. anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of any anaphylaxis?			
Have you had a severe allergic reaction (ie. anaphylaxis, trouble breathing) to any component of a COVID-19 vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?			
Have you received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next 14 days?			
Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 30 days?			
Have you tested positive for COVID-19 in the last 10 days?			
Are you currently in quarantine for COVID-19 exposure?			
Do you have a bleeding disorder or are you taking a blood thinner?			
Are you currently undergoing chemotherapy or radiation treatment for cancer?			
If you are a woman: Are you currently pregnant or breast feeding?			
*If this is your **second** dose: What date was your first dose?*			
Which vaccine did you receive (ie. Pfizer, Moderna, etc.)?			

I have reviewed the questions above and answered to the best of my ability with the vaccinator. If I experience any adverse reactions after leaving, I will notify my Primary care provider. I have viewed the Emergency Use Authorization Fact Sheet provided to me today. I understand the benefits and risks associated with the vaccine. I will hold harmless Commonshare or other onsite contractors for harm which would be attributable to the injection. The vaccine listed should be given to the person named above for whom I am authorized to make this request. I have been given the opportunity to review the Notice of Privacy Practice at the time of vaccination, and acknowledge this document is available at any time for future review. I also attest to being truthful and of sound mind regarding my insurance coverage status. I agree to allow Commonshare to bill my insurance or seek reimbursement from HRSA CareAct funding which will include disclosure of personal and medical information.

Signature of Parent/Guardian/Patient	Date

Vaccine Name/Manufacturer	Lot Number/Expiration Date	Route/Site	Administrator	Date
MODERNA		IM LD ☐ RD ☐		