Encompass Medical Group
COVID-19 VACCINE CONSENT FORM 2026-27

Patient Name: _____ **Birthdate:**_____

PRECAUTIONS AND CONTRAINDICATION	Yes	No
Are you sick today with COVID type symptoms or an acute illness with fever?		
Do you have a history of any severe allergies causing anaphylaxis to any vaccine, injectable therapy (intramuscular, intravenous or otherwise) or to any other substance?		
Any prior history of allergic reactions to polyethylene glycol, iodinated contrast media, MRI contrast, intravenous steroid or any active ingredient in the COVID 19 vaccine?		
Are you immunocompromised or on a medication that affects your immune system (such as cancer, rheumatoid arthritis, Crohn's disease or other immune system issue)?		
Do you have any bleeding disorder or are you on blood thinner?		
Are you currently pregnant or breast feeding? (Female only)		
Have you recently been diagnosed with COVID-19?		
If yes, has it been greater than 10 days?		
Have you received monoclonal antibodies or convalescent plasma for COVID 19 treatment within the last 90 days?		
Have you received any other vaccines within the past 14 days?		
Vaccination information given and explained to patient		
Have you ever received a dose of COVID vaccine? If so, which vaccine: ☐ Moderna ☐ Pfizer ☐ Johnson and Johnson		
Do you have dermal fillers?		

CONSENT REGISTRATION FORM

I have read the information about the COVID 19 vaccine and the possible side effects. I have had an opportunity to ask questions regarding vaccination recommendations and understand the benefits and risks of the COVID vaccination as described and understand it is a two series injection. I request and consent that the COVID-19 vaccine be given to me.

Indications for COVID-19 have changed and some insurance carriers may not pay for your vaccination without specific immunocompromised indications. In the case that your insurance carrier does not cover or pay for the vaccination, I understand that I will be financially responsible and will be expected to pay for the vaccination and administration.

_____ _____

Patient Name (please print) Patient Signature

COVID-19 Vaccine Administration Information

Date:_____ **Time:**_____ **Type:** _____

R L Deltoid **Manufacturer**: _____

Given By:_____ **Lot #:** _____