SIA SURGICAL INSTITUTE OF ALABAMA

COVID-19 Vaccine Consent Form

PERSONAL INFORMATION ABOUT INDIVIDUAL TO RECEIVE VACCINE					
Last Name	First Name		M.I	Gender: Male ☐ Female ☐	
Date of Birth	Age	Social Security #	Telephone Number	Alternate Number	E-mail
Street Address					Apt. Number
City	County		State	Zip Code	

INSURANCE INFORMATION			
Name of Insurance Company	Member ID Number/Contract Number	Group Number	Relationship to Subscriber: Self ☐ Spouse ☐ Other: ______________
Subscriber Name (if different than patient)	Subscriber Birthdate	Subscriber Street Address, City, State, and Zip Code	
Secondary Insurance	Member ID /Contract Number	Group Number	Subscriber Name

In the event of an emergency, please provide:		
Emergency Contact	Relationship	Telephone Number

VACCINATION AND HEALTH-RELATED INFORMATION: If you answer Yes to questions 1 - 4, consult a health care provider before receiving the vaccine.	**YES**	**NO**
1. Does the patient have long-term health problems with: immunocompromised condition or taking a medicine that affects your immune system?		
2. Have you ever had a life-threatening reaction to any vaccine or to a vaccine component (example eggs, polyethylene glycol, polysorbate, sulfites, thimerosal, gelatin, neomycin or phenol)? **If yes, list:**		
3. For Women: Are you pregnant or considering becoming pregnant in the next three months or currently nursing ? If male, circle: NA		
4. Has the patient had a seizure or any other brain or other nervous system problem (i.e., Guillain-Barre Syndrome) after receiving vaccine?		
Has the patient ever received COVID-19 vaccination? **If yes, date given:** **Manufacturer**:		

I hereby certify that the above history is true and complete to the best of my knowledge. I have received the Emergency Use Authorization (EUA) Fact Sheet. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of requested Vaccine and ask that the Vaccine be given to me. I understand that if I receive the Moderna vaccine, I will be receiving two (2) doses of vaccine 21 - 28 days apart. I understand that I may not have the full vaccine protection until after the second dose. I understand my information and Vaccine(s) I receive will be entered into the Alabama Department of Public Health Immunization Registry. I give permission for SURGICAL INSTITUTE OF ALABAMA to provide my medical treatment. I allow SURGICAL INSTITUTE OF ALABAMA. to file for insurance benefits to pay for the care I receive. I assign my insurance benefits to be paid directly to SURGICAL INSTITUTE OF ALABAMA. I understand that SURGICAL INSTITUTE OF ALABAMA may have to send my medical record information to my insurance company. I understand I have the right to refuse any procedure or treatment and I have the right to discuss all medical treatments with my clinician. I waive and release all claims I, or anyone claiming by or through me, now have or may hereafter acquire against SURGICAL INSTITUTE OF ALABAMA, and their respective directors, officers, employees, and agents for any damage or injuries if I, or the person named above for whom I am authorized to make this request, contract the illness prevented by the Vaccine, other diseases, or suffer any other adverse reactions following administration of this Vaccine.

Signature of Individual/Parent/Legal Guardian ______________________ Date ____________

For Clinic Use only

Date Vaccine and Fact Sheet Given	Type and Date of Fact Sheet	Circle Dose Given 1st Dose 2nd Dose
Vaccine NDC & Lot Number	Injection Site LA RA	Route IM
Administer Signature and Printed Name		

You may send the completed form via Fax to: 205-870-7735 or email to: covid@siaasc.com or bring to your appt.