



COVID-19 VACCINATION CONSENT FORM

I have been given a copy of and have read, or have had explained to me, the information contained in the Emergency Use Authorization (EUA) Recipient Fact Sheet for the _____ (brand) COVID-19 vaccine. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine.

By signing this form, I acknowledge I have been made aware of the Notice of Privacy Practices of Santa Barbara County Public Health Department. It is available at <https://countyofsb.org/ceo/hipaanoticesofprivacy.sbc>. It provides information about how Santa Barbara County Public Health Department uses and discloses protected health information.

By signing this form, I acknowledge I have been made aware of the California Immunization Registry (CAIR) Notice to Patients and Parents available at <http://www.cairweb.org/cair-forms>. I understand that my or my child's immunization data will be entered in the CAIR system, and that I have the right to opt out of having my or my child's information shared with other organizations.

By providing my cell phone number and/or email address below, I give the Santa Barbara County Public Health Department and participating vaccination partners permission to contact me regarding important vaccine reminders. I have been advised about the administration process for the vaccine I or my child is about to receive and given consent for the vaccination (s).

I hereby authorize that this vaccine be given to me or to the person named below for whom I am authorized to consent.

PLEASE COMPLETE BOTH PAGES, SIGN AND DATE

Name of Patient: _____

Signature of Adult Patient or Parent/Guardian/Caregiver if a minor patient:

_____ Date: _____

Name of Insured: _____ Insurance Provider: _____

Policy Number _____ Group Number _____



PLEASE COMPLETE BOTH PAGES, SIGN AND DATE

				<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Decline to state
Last Name	First Name	MI	Birthdate	Sex
Street Address	City	Zip Code	Contact Phone	
Parent / Guardian - Last name		Parent / Guardian- First Name		
<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> White <input type="checkbox"/> Multiracial <input type="checkbox"/> Other <input type="checkbox"/> Decline to state				
		Preferred language, if not English		
Race/Ethnicity	Email:			

FOR OFFICE USE ONLY		
<input type="checkbox"/> Pfizer <input type="checkbox"/> J&J <input type="checkbox"/> Moderna Vaccine Brand	<input type="checkbox"/> RA <input type="checkbox"/> LA Injection Site	Mfg/Lot #
Administered by Signature	Administered by Title	Date Administered