



**FREMONT COUNTY DEPARTMENT OF
PUBLIC HEALTH & ENVIRONMENT**

201 N. 6th Street
Cañon City, CO 81212
P: 719-276-7450 F: 719-276-7451

COVID-19 Vaccine Consent Form

Name: _____ Date of Birth: _____ M: _____ F: _____

Phone #: _____ Type of Phone (Circle one): Home Cell Work

Address: _____ City: _____ State: _____ Zip: _____

General Consent: Vaccination Consent

By signing this form, I give permission to be vaccinated with a COVID-19 vaccine. Further, I agree that information shared through PrepMod while scheduling a COVID-19 Vaccine appointment is true and correct as of today's date indicated below, and:

- * I have read or had explained to me information about the vaccine;
- * I understand the risks and benefits of being vaccinated and consent to be vaccinated;
- * I have had a chance to ask questions which were answered to my satisfaction; and
- * I hereby release this provider, its employees and its volunteers from any liability for any results which may occur from the administration of this vaccine.

CIIS Notification Information

Your/your child's vaccine information is being reported to the Colorado Immunization Information System (CIIS), a confidential, secure, statewide immunization registry. You may choose to exclude your/your child's information from CIIS at any time. Please see your healthcare provider for further information.

INSURANCE/PAYMENT INFORMATION-

No Insurance (NI) [] Alaska Native (AN) [] American Indian (AI) []

Medicare #: _____ Medicaid #: _____

Private Insurance Name: _____

Policy #: _____ Group/Plan: _____

Subscriber's Name: _____ Subscriber's DOB: _____

By signing below, I hereby authorize Fremont County Department of Public Health & Environment to bill my insurance for reimbursement and request that payment of authorized benefits be made to Fremont County Department of Public Health & Environment.

I have been given a copy and have read, or have had explained to me, the information in the Vaccine Information Sheet. I have had a chance to ask questions and they were answered to my satisfaction. **I attest that the above information is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health.** I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me. I understand that it will not be fully effective for approximately two weeks. However, as with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I understand that one should not receive this vaccine if they have a **severe** allergy to eggs, have had a severe reaction to a previous influenza vaccine, or if they have had Guillain-Barre Syndrome.

Patient/Parent Signature: _____ **Date:** _____