COVID-19 Vaccination Consent Form

Date: __________

Patient Name: ________________________________

Date of Birth: ________________________________

Address: _____________________________________

Phone Number: ________________________________

Vaccine Information

Type of Vaccine: ______________________________

Provider Name: _______________________________

Consent Statement

I, the undersigned, hereby give my consent for the administration of the COVID-19 vaccine. I understand the benefits and risks associated with the vaccine and have had the opportunity to ask questions.

Signature: ___________________________________

Date: _______________________________________

Emergency Contact

Name: _______________________________________

Phone Number: ________________________________