Cigna Medical Group℠

Epic Patient Visit Label Required

COVID-19 Vaccine Consent Form

Patient Information

Last Name _____ First Name _____

Mother's Maiden Name (Optional) _____ Date of Birth (MM/DD/YYY) _____

Address _____ Apartment Number _____ City _____ State / Zip _____

○ **No address available** Phone Number: _____

Is this the patient's first or second dose? ○ First ○ Second

Insurance Information

Do you have insurance? ○ Yes ○ No

If No, please provide either **Driver's License #/State** or **Social Security # (SSN)**: _____

Plan Name _____ Plan Group ID# _____ Plan Individual ID# _____

Name of Person Covered by Plan _____ Plan Responsible Person Name _____

Private Insurance Address/Phone Number (if available) _____

ASSIGNMENT OF BENEFITS: I hereby assign to Cigna Medical Group any insurance or other third-party benefits available for the administration fee of the COVID-19 vaccine provided to me. I agree to forward to all health insurance and other third party payments I receive for services rendered to me immediately upon receipt. I agree to allow the health care provider to release information to the Arizona State Immunization Information System (ASIIS) to record that I (or for the person for whom I am authorized to consent) have received this COVID-19 vaccine. This information will help keep track of the manufacturer and doses of the vaccine.

I have had a copy of the Emergency Use Authorization for the COVID-19 vaccine made available to me. I have had a chance to ask questions and believe I understand the benefits and risks of the COVID-19 vaccine made available to me. I have had a chance to ask questions and I believe I understand the benefits and risks of the COVID-19 vaccines requested. I ask that the vaccine be administered to me or the person for whom I am authorized to make this request.

Printed Patient Name _____ Patient Signature _____ Date Signed _____

Authorized Person's Printed Name (if applicable) _____ Authorized Person's Signature _____ Date Signed _____

COVID-19 Screening Questions

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "Yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you feeling sick today?	○	○	○
2. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? _____	○	○	○
3. Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen© Or for which you had to go to the hospital?	○	○	○
• Was the severe allergic reaction after receiving a COVID-19 vaccine?	○	○	○
• Was the severe allergic reaction after receiving another vaccine or Another injectable medication?	○	○	○
4. Do you have a bleeding disorder or are you taking a blood thinner?	○	○	○
5. Have you received passive antibody therapy as treatment for COVID-19?	○	○	○

For more information, please refer to the CDC pre-vaccination form for the specific vaccine you are giving.

Vaccine Administration Information for Immunizer Use Only

Administration Date	Manufacturer	NDC#	
		○ Left arm	○ Right Arm
Lot Number	Expiration Date	Route	Site
Administering Immunizer Name and Title	Administering Immunizer Signature	Date/Time	