NEW MEXICO Department of Health
Public Health Division

COVID-19 VACCINE CONSENT FORM

This form is to be used for patients aged 16 years of age and older ONLY

Revised 03/01/2021

□ **Dose #1**
□ **Dose #2**

Last Name:_____ **First Name**:_____ **Middle Initial**:_____

Birth Date:_____ **Mother's Maiden Name**:_____
Month / Day / Year *First and Last Name*

Mailing Address:_____ **City**:_____ **State**:__NM____ **Zip**:_____

Daytime Phone:_____ Emergency Contact:_____**Relationship**:_____
First and Last Name

Gender: ☐ Male ☐ Female

Race: ☐ American Indian/Native American/Alaskan Native ☐ Asian ☐ Other ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

INSURANCE INFORMATION – Fill the appropriate category – REQUIRED

Centennial Care/Medicaid: ☐ Blue Cross Blue Shield ☐ Presbyterian ☐ Western Sky
Policy/ Member ID #_____ Centennial Care Medicaid #: _____Group #:_____
Medicare Part B:
Subscriber ID #_____ Responsible Party:_____ Policy Holder's Date of Birth: _____

☐ No Insurance ☐ Private Insurance

MEDICAL SCREENING QUESTIONS - REQUIRED

For patients: The following questions will help us determine if you should be given the vaccine today. If you answer "**yes**" to any question, it does not necessarily mean you should not be vaccinated. It just means that additional questions must be asked. If a question is not clear, please ask your health care provider to explain it.	No	Yes	Don't Know
1. Are you sick today?			
2. Do you have allergies to medications, food, a vaccine component, or latex? Please list: _____ *If allergy to COVID vaccine, do not vaccinate; if other allergy, monitor 30 min.*			
3. Have you ever had a serious reaction after receiving a vaccine, including a prior dose of COVID-19 vaccine?			
4. Do you have a bleeding disorder or are you taking a blood thinner? *If yes, be aware of possible bleeding/bruising.*			
5. For women: Are you pregnant or is there a chance you could become pregnant during the next month? *If yes, first consulted with a provider (OBGYN or primary care)*			
6. For women: Are you nursing (breastfeeding) a child?			
7. Have you received any vaccinations in the past 14 days? *If yes, consult with provider: recommended but not contraindicated if receive other vaccine 14 days before/after.*			
8. Have you tested positive for COVID 19 in the last 10 days? *If yes, re-schedule vaccination for after isolation.*			
9. Have you received a COVID-19 vaccine in past? *If yes, be sure of timing and manufacturer for second dose (if indicated).*			
10. Have you received monoclonal antibody or convalescent plasma for COVID-19 treatment in last 90 days? *If yes, consult with provider: recommended re-schedule vaccination for 90 days after treatment.*			
11. Do you have an immune-suppressing condition or medicine? *If yes, be aware that vaccine effectiveness may be limited.*			

CONSENT FOR VACCINATION

I have been given and have read or have had explained to me, the information in the "FACT SHEET FOR RECIPIENTS AND CAREGIVERS" for the vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine requested and ask that the vaccine checked below be given to me or the person named for whom I am authorized to make this request. I request that payment of authorized benefits be made to the New Mexico Department of Health/Public Health Division/Immunization Program, for services furnished to me by that program. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. I specifically authorize the release of my Medicare or other insurance policy number to the NM Department of Health to allow the Department of Health to seek reimbursement for the vaccine and administrative costs. Unless I sign a statement signifying otherwise, I allow immunization information to be entered into the New Mexico Statewide Immunization Information System (NMSIIS) and be released to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status. The DOH Privacy Policies are available at http://nmhealth.org/hipaa.shtml and will be given to all patients when they receive an immunization.

Signature (Client/Guardian):_____ **Date:**_____

FOR CLINIC USE ONLY

Vaccine	Lot #	Exp. Date	Site & Route	Date of EUA
COVID-19 Pfizer (59267-1000-02)				
COVID-19 Moderna (80777-0273-99)				
COVID-19 Janssen (59676-580-15)				

Vaccinator (print name):	Signature:	Date of Service:
Title of Vaccinator:	VFC Pin#:	Date Fact Sheet Given:
Date NMSIIS Entered:	Date TransactRx Entered:	Notes:
Address/location of vaccines given:		

DIRECT NMSIIS ENTRY OF VACCINES ADMINSTERED IS REQUIRED. FOR NM DOH OUTREACH ONLY: Data must be entered into TransactRx within 30 days of the date of service.

This form was designed for NM DOH public health offices use only. NM DOH is not responsible for data entry from outside health entities.