RANKIN COUNTY HOSPITAL DISTRICT

# COVID-19 VACCINE RELEASE FORM

**Date: _____ Recipient Full Name: _____**

**SSN: _____ Date of Birth: _____ Gender: Male _____Female_____**

**Address: _____City: _____**

**State: _____ County: _____ Zip: _____**

**Phone: _____ Mother's Full Maiden Name: _____**

**Choose Race: American Indian/Alaskan Native_____ Asian_____ Black/African American_____**

**Native Hawaiian/Pacific Islander_____ White _____ (choose if White or Hispanic)**

**Choose Ethnicity: Hispanic or Latino_____ Not Hispanic or Latino_____**

## COVID-19 VACCINE CONSENT (18 YEARS OF AGE AND OLDER)

**Please Initial Each Item:**

**_____ I have been informed that the COVID-19 vaccine is an unapproved vaccine that has been authorized for use by the FDA under Emergency Use Authorization.**

**_____ I have received the "Fact Sheet for Recipients and Caregivers."**

**_____ I understand that the COVID-19 vaccine is not mandatory.**

**_____ I understand the significant known and potential risks and benefits of the COVID-19 vaccine, and the extent to which such risks and benefits are unknown.**

**The following question only applies to individuals who suffer from ANAPHYLAXIS, ARE PREGNANT, OR CURRENTLY BREAST FEEDING:**

**_____ I have consulted with my primary care physician about the potential risks of the COVID-19 vaccine.**

**……**

**_____ _____**

**Patient or Parent/Caregiver Date**

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**RD:_____ LD:_____ Nurse (print name): _____**

**LOT# _____ Signature: _____**

**Expiration: _____ Date: _____**