AlixaRx COVID-19 Vaccine Consent Form

Section 1: Information about the Person Receiving the Vaccine – Recipient *(Please Print)*

Recipient Name (Last)	(First)	(M.I.)	**Date of Birth** (MM/DD/YYYY)	**Age**
Authorized Power of Attorney (POA)/Legal Guardian Name (Last)	(First)	(M.I.)	**Recipient/POA Phone Number**	
Recipient Address	**City**	**State**	**Zip Code**	
Known Allergies			**Social Security Number**	
Gender Assigned at Birth Female / Male / Unknown	**Race** Asian / African American / American Indian Caucasian / Hispanic / Pacific Islander Two or More / Unknown	**Ethnicity** Hispanic-Latino / Non-Hispanic-Latino / Unknown		
Facility Resident Information (Not needed for non-residents)				
Primary Provider Name (Last)	(First)	(M.I.)	**Provider's NPI**	
Facility Name		**Room Number**	**Bed**	

Section 2: Vaccination History

1) Has the recipient previously been vaccinated with a COVID-19 Vaccine? **Yes** ☐ **No** ☐

If yes to above, there are multiple kinds of COVID-19 vaccine. Your answers to the following questions will help us understand which vaccine (or step) to provide.			
Vaccine Manufacturer	Pfizer / Moderna / Johnson & Johnson (Janssen)	**Injection Site**	Left Arm / Right Arm
Date of Dose #1	**Month** _____ **Day** _____ **Year** _____		
Date of Dose #2 (If Applicable)	**Month** _____ **Day** _____ **Year** _____		
Date of Dose #3 (If Applicable)	**Month** _____ **Day** _____ **Year** _____		

Section 3: Consent

I understand I will be provided an Emergency Use Authorization Fact Sheet or a Vaccine Information Statement prior to the date of the vaccination and have the ability to revoke consent at any time. I understand that the providers of this vaccine cannot be held responsible to any adverse reactions to the vaccine being administered.

☐ **I GIVE CONSENT** to ALIXARX and its staff/partners for the person named at the top of this form to be vaccinated with this vaccine. **(If this consent form is not signed, then this person will not be vaccinated)**

☐ **I DO NOT GIVE CONSENT** to the ALIXARX and its staff/partners for the person named at the top of this form to be vaccinated with this vaccine.

Resident signature OR Signature/Printed Name of Health POA OR Name of Health POA/verbally acknowledged by licensed staff (sign & print name & credentials):

Printed Name/Signature: _____

Date (MM/DD/YYYY): _____