

VERMILION COUNTY HEALTH DEPARTMENT

MODERNA COVID 19 CONSENT / ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the Vermilion County Health Department's Notice of Privacy Practices on the date stated below.

I give my consent to receive the Moderna Covid 19 vaccine. I understand that there are risks and benefits associated with any vaccine. I have received the vaccine information sheet (s).

I authorize Vermilion County Health Department to release service-related information regarding the person mentioned below to third party payors and/or other health practitioners and to bill for service rendered to me, if applicable. I request my payor to pay VCHD directly for services rendered to me.

PRINT NAME

SIGNATURE

DATE

CLIENT IF DIFFERENT

Moderna Lot # _____

Date/Next Shot to be Received _____

INITIALS OF VACCINE ADMINISTRATOR

MODERNA COVID 19 DEMOGRAPHICS

LAST NAME _____

FIRST NAME _____

MIDDLE INITIAL _____

DOB _____

MALE _____ FEMALE _____

MAILING ADDRESS _____

CITY _____

STATE _____

ZIP _____

PHONE _____

EMAIL (opt.) _____

Occupation (Please Check One)

- LTCF (Long-Term Care) Staff
- EMS
- Hospital-Based Staff
- LHD Staff
- Clinic Facility Staff
- Home-Health Personnel
- Pharmacy Staff
- Other Medical Staff (dental, opt. etc)
- Other Healthcare Workers