Rockcastle Regional Hospital
COVID-19 Vaccine Consent Form

Section A: Patient Information			
First Name	**MI**	**Last Name**	**Date of Birth**
Social Security Number		**Gender**	
Phone Number			
Address		**City, State, Zip**	
Any Allergies?		**Primary Care Doctor (PCP)**	

Section B: Consent for Vaccination

I certify that I am a) the patient and at least 18 years old; b) the parent or legal guardian of the minor patient; or c) the legal guardian of the patient. I hereby give my consent to receive the Covid-19 vaccine. I have requested this vaccine. I understand it is not possible to predict all possible side effects or complications associated with receiving a vaccine. I understand the risks and benefits of the Covid-19 vaccine and have read or had explained to me information consistent with a Vaccine Information Statement or an Emergency Use Authorization Fact Sheet for Patients and Caregivers. I acknowledge that I have been advised to remain near the vaccination location for a period of 15 minutes after receiving the vaccine. I acknowledge that the Kentucky Immunization Registry and the Primary Care Provider listed above will receive record of my receipt of this vaccine. I hereby release and hold harmless each provider, staff, agents, successors, officers, directors, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the Covid-19 vaccine.

I authorize billing the insurance listed and the release of any medical or other information necessary to process an insurance claim. I understand that Rockcastle Regional Hospital may disclose this information to my Primary Care Provider listed above, health systems and hospitals, payment or other health care operations.

Patient Signature:_____ **Date:** _____

Parent/Guardian Signature_____ **Date:** _____