GOODALL-WITCHER
Healthcare

Goodall-Witcher Hospital
Goodall-Witcher Clinic in Clifton
Goodall-Witcher Clinic in Whitney
Goodall-Witcher Home Health Agency
Goodall-Witcher Nursing Facility
Goodall-Witcher Fitness & Wellness Center

COVID-19 Vaccine Consent

Patient Name: _________________________ Date of Birth: ____________ Phone: _______________

Primary Care Physician/Clinic: ________________________

Address: ____

__ I have not received an antibody infusion in the last 90 days.

__ I have received the Vaccine Information Statement provided to me

__ I consent to receive the COVID-19 Vaccine and authorize reporting this information to ImmTrac2

____ ______________

Signature Date

Office Use Only:

Dose # 1 Dose #2 Dose #3

Vaccine: Place Label Here

Dosage: 0.5ml IM 0.3ml IM 0.25ml IM Site: L or R deltoid

Administered by:_____________________________________ Date:_________________