

**COVID-19 VACCINE INFORMATION AND CONSENT FORM**

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| **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  First Middle Last | | | | | | | | | | | | | |
| **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_  Street City State Zip | | | | | | | | | | | | | |
| **Telephone:** (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_--\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SSN | | | | | | | | | | | | | |
| **Date of** **Birth:**  \_\_\_\_\_\_**\_--\_\_\_\_\_\_\_--\_\_\_\_\_\_\_\_\_** | | | Age: | | **Gender:**  Male   Female | | **Primary Language:**   English  Other \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **Ethnicity: (check only 1)**   Not Hispanic   Hispanic  Unknown | | | |
| **Race: (check only 1)** Asian/Polynesian Black Multiracial White Native Am/Alaskan Unknown | | | | | | | | | | | | | |
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| **Please answer the health questions below:** | | | | | | | | | | | **Yes** | **No** | **Do Not Know** |
| 1. Are you sick today or currently in an isolation period for COVID-19? | | | | | | | | | | |  |  |  |
| 2. Have you had a positive COVID-19 test in the last 90 days and received convalescent plasma? | | | | | | | | | | |  |  |  |
| 3. Are you allergic to anything including any food, any vaccine, any vaccine component, latex, or polyethylene glycol? | | | | | | | | | | |  |  |  |
| 4. Do you have an adrenaline auto injector (EpiPen) for severe allergic reactions? | | | | | | | | | | |  |  |  |
| 5. Have you ever had a serious reaction after receiving a vaccination or IV injectable medications? | | | | | | | | | | |  |  |  |
| 6. Have you received any vaccinations in the past two weeks? | | | | | | | | | | |  |  |  |
| 7. Are you currently receiving anticoagulation therapy, or do you have any type of bleeding disorder? | | | | | | | | | | |  |  |  |
| 8. Do you, anyone you live with or take care of, have a weakened immune system? | | | | | | | | | | |  |  |  |
| 9. Do you, anyone you live with or take care of, take steroids, anti-cancer drugs or x-ray treatments? | | | | | | | | | | |  |  |  |
| 10. Is it possible that you are or may become pregnant in the next four weeks? | | | | | | | | | | |  |  |  |
| 11. Are you currently breastfeeding? | | | | | | | | | | |  |  |  |
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| I have been given a copy and have read the Emergency Use Authorization (EUA) or the Vaccine Information Statement (VIS) for the COVID-19 Vaccine. I have had the chance to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of the vaccine requested and ask that the vaccine indicated be given to me or the person named for whom I am authorized to make this request.  **My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine.**  **Those with previous anaphylactic reactions should stay for 30 minutes.**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date Print Name Patient/Guardian** **Signature** | | | | | | | | | | | | | |
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| **OFFICE USE ONLY Record of Immunization OFFICE USE ONLY** | | | | | | | | | | | | | |
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| **Manufacturer** | **Lot #** | **Expiration** | | **Dosage** | | **Route** | | **Site** | **EUA/VIS** | | **Provider Signature/Date** | | |
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**D4 12/2020**