Vaccine Event Location _____

COVID-19 Vaccine Consent Form

Patient Information (Vaccine Recipient):

Name (Last)	(First)	**Date of Birth**	**Gender** ☐ Male ☐ Female ☐ Other

Email	**Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino **Race:** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White ☐ Other Race
Are you a member of federal or state recognized tribal nation? ☐ Yes ☐ No	
Address	

City	**State**	**Zip**	**Phone Number**

Please check all disabilities that apply to you:

☐ **Not Disabled** ☐ **Cancer** ☐ **Cognitive (Psychological or Psychiatric)** ☐ **Neurological** ☐ **Physical (Mobility)**

☐ **Respiratory** ☐ **Sensory (Vision or Hearing)** ☐ **Other (Please Specify)**_____

Emergency Contact Name: **Relation:** **Phone Number:**

Screening Questions:

Question	YES	NO	Don't Know
1. **Do you have new onset fever, chills cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea, or are you otherwise not feeling well?** If yes, you have symptoms that could be consistent with COVID-19. Please obtain testing before receiving your vaccination.	☐	☐	☐
2. **Are you currently in isolation for a recent COVID infection or under quarantine for a recent exposure?** If yes, you cannot receive a vaccine while you are under isolation/quarantine. Please re-schedule when you are out of isolation/quarantine.	☐	☐	☐
3. **Have you ever had an allergic reaction to a prior dose of COVID-19 vaccine?**	☐	☐	☐
4. **Have you ever had a severe allergic reaction to something other than a COVID-19 vaccine?** This would include food, pet, environmental or oral or injectable medication allergies. (A severe allergic reaction includes a reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐
5. **Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?** *[note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]*	☐	☐	☐
6. **Are you currently taking blood thinners or do you have a bleeding disorder?**	☐	☐	☐

Consent (check each box below after reading and signing):

- ☐ I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet, a copy of which I was provided with this Consent Form. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent Form.
- ☐ I understand that at this time, the COVID-19 vaccine requires 1 (Janssen) or 2 doses (Pfizer/Moderna) given 21 or 28 days apart depending on the manufacturer. If this is my first dose of the COVID-19 vaccine, I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the vaccination series.
- ☐ I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur.
- ☐ I understand that I will be receiving the vaccination at no cost to me.

Signature of Person to Receive Vaccine & EUA /VIS (or Signature of Parent/Guardian if Patient is < 18 years old)

Signature: _____ **Date: _____**

*****OFFICE USE ONLY*****

Vaccine	Dose	Route	Vaccine Manufacturer	Lot Number
COVID-19	☐ 1st Dose ☐ 2nd Dose	☐ IM - Left Deltoid ☐ IM - Right Deltoid	☐ Moderna ☐ Pfizer ☐ Janssen	

Vaccinator Signature: _____
Date:_____

Site Lead MD who reviewed this form if different from the vaccinator: _____