COVID-19 VACCINE BOOSTER DOSE CONSENT FORM

Information about person to receive vaccine (please print)

Name: _____ **Birth date**: ___/___/_____ **Age**: _____ **Sex**: ☐ Male ☐ Female

Please answer the following questions:

Has the person to be vaccinated ever received a COVID-19 vaccine?	☐ No ☐Yes
If yes, date(s):_____ Type/Brand of COVID vaccine:_____	
Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy?	☐ No ☐Yes
Is the person to be vaccinated sick today?	☐ No ☐Yes

VOLUNTARY CONSENT TO COVID-19 VACCINE:

I understand that COVID-19 can have serious life-threatening complications (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html), and there is no way to know how COVID-19 will affect me. I further understand that a COVID-19 vaccine may help keep me from becoming seriously ill, even if I do become infected with COVID-19.

I have reviewed my specific vaccine EUA Fact Sheet or have had its contents including the benefits, the usual and most frequent risks of receiving this vaccine, and alternatives explained to me, based upon currently available information. I have had an opportunity to ask questions which have been answered to my satisfaction. I agree to remain at the vaccination location for at least 15 minutes after vaccine is administered in the event of adverse reaction.

I acknowledge and understand that the current recommendation for an additional dose of mRNA COVID-19 vaccine following their initial 2 dose series of a limited population at this time. It has been at least 4 weeks since the 2nd vaccine and I self-attest to the following condition:

☐ have been receiving active cancer treatment for tumors or cancers of the blood
☐ received an organ transplant and are taking medicine to suppress the immune system
☐ received a stem cell transplant in the last 2 years/are taking medicine to suppress the immune system
☐ moderate or severe primary immunodeficiency
☐ advanced or untreated HIV infection
☐active treatment with high-dose corticosteroids/other drugs that may suppress your immune response

OR

☐ **I acknowledge and understand that the current recommendation for a Bivalent booster dose of COVID-19 vaccine is for anyone ages 5 years and older that is 2 months since primary vaccination or recent booster of a monovalent vaccine. I self-attest it has been at least 2 months since the 2nd vaccine dose or booster dose.**

I understand and acknowledge record of this vaccine administration to me will be reported to the state and/or federal regulatory bodies in compliance with reporting for inventory management and use of National Stockpile vaccine supply.

☐ I acknowledge this information and consent to receiving the COVID-19 vaccine.

I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

The above information is true to the best of my knowledge. If qualified, I authorize billing to my insurance company and release of information required to process my claims.

Print Parent/Guardian name, if different from patient: _____

Patient/Parent/Guardian Signature: _____Date: _____