COVID-19 VACCINE CONSENT FORM

Information about person to receive vaccine (please print)

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

The following questions will help determine if there is any reason you should not receive a COVID immunization injection.

Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.

Question	No	Yes
Has the person to be vaccinated ever received a COVID-19 vaccine?	☐ No	☐Yes
If yes, date:________________ Type/Brand of COVID vaccine:_____________________		
Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex?	☐ No	☐Yes
List all allergies: ____		
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
Is the person to be vaccinated have a weakened immune system cause?	☐ No	☐Yes
Is the person to be vaccinated taking immunosuppressive drugs or therapies?	☐ No	☐Yes
Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner?	☐ No	☐Yes
Has the person to be vaccinated received any other vaccines in the past 14 days?	☐ No	☐Yes
Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19?	☐ 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. Depending upon the COVID-19 vaccine that I receive, I may require one or two injections. 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 understand that:

• This vaccine is authorized for use under Emergency Use Authorization (EUA) issued by the U.S. Food and Drug Administration (FDA). Under an EUA, the FDA may allow the use of unapproved medical products, or unapproved uses of approved medical products, in an emergency to diagnose, treat, or prevent serious or life-threatening diseases or conditions when certain statutory criteria have been met, including that there are no adequate, approved, and available alternatives.

• It is unclear how long any potential benefits of the vaccine may last. Additional research is needed to answer this question.

• Receiving this vaccine does not eliminate the need for masking, social distancing, and hand hygiene.

• I may still become ill with COVID-19 and may be able to transmit the virus to other individuals.

• This vaccine has not been studied on individuals who are pregnant or breastfeeding and it is recommended that I discuss vaccination with my provider prior to receiving vaccine.

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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: ______________