COVID-19 VACCINATION CONSENT FORM

Last Name (Print)	First Name	M.I.	Date of Birth	Age

Address	City	State	ZIP

Phone Number	☐ Male ☐ Female	Mother's First Name	Mother's Maiden Name

☐ **I am 65 years or older.**

SCREENING FOR VACCINATION ELIGIBILITY

You should <u>not</u> get vaccinated if you:

- are under 18 years of age.
- had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause.
- had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of a COVID-19 Vaccine, including lipid nanoparticles or polyethylene glycol (PEG).
- received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next 14 days.
- received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days.

Talk to your doctor about whether you should receive the COVID-19 vaccine if you:

- are pregnant or breastfeeding.
- are currently sick. For example, if you are experiencing fever, chills cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.
- have a bleeding disorder or are taking a blood thinner.
- are currently in quarantine for COVID-19.
- have tested positive for COVID-19 in the past 90 days.

Do you have any of the following conditions? (Check all that apply.)

☐ Lung Disease ☐ Heart Disease ☐ Asthma ☐ Kidney Disease ☐ Diabetes
☐ Obesity/Severe Obesity ☐ Pregnancy ☐ Smoker ☐ Down Syndrome ☐ Hypertension
☐ Neurological Disorder ☐ Stroke ☐ None of the above ☐ Other:_____

Do you have any of the following immunocompromised conditions? (Check all that apply.)

☐ Cancer ☐ Leukemia ☐ Lymphoma ☐ HIV/AIDS ☐ Transplant
☐ Blood Disorder ☐ Liver disease ☐ Sickle Cell Disease ☐ Anemia ☐ None of the above
☐ Other:_____

CONSENT FOR VACCINATION

I've had the opportunity to discuss my concerns with my doctor. If I experience any adverse effects after leaving, I will notify my primary care provider and administrator. **I have reviewed the Emergency Use Authorization face sheet provided to me today.** The administration of this vaccine does not create a patient provider relationship between administrator and recipient. I understand that my information and vaccination status will be reported to the state. I understand the benefits and risks of the vaccine and freely and voluntarily request to receive the COVID-19 vaccine.

Signature of Parent/Guardian/Patient:_____ Date:_____

FOR ADMINISTRATIVE USE ONLY:

Manufacturer:	Exp. Date:	Route IM: ☐ Right Deltoid ☐ Left Deltoid	Time/Date Vaccine Given:
Lot #:			Signature of Vaccine Administrator: