



COVID-19 Vaccine INFORMATION AND CONSENT FORM

NAME (Last)	(First)	Date of Birth: _____/_____/_____	Age:	
ADDRESS				
CITY	STATE	ZIP	DAYTIME PHONE NUMBER	
EMERGENCY CONTACT:				
Name		Relation	Phone Number	
Race: (check only 1) <input type="checkbox"/> Asian/Polynesian <input type="checkbox"/> Black <input type="checkbox"/> Multiracial <input type="checkbox"/> Native Am/Alaskan <input type="checkbox"/> White <input type="checkbox"/> Unknown		Ethnicity: (check only 1) <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Other _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

Insurance Company:	Insurance Policy Number:
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Please answer the health questions below:	Yes	No	Do Not Know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine? *If yes, which vaccine product: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen <input type="checkbox"/> Other: _____			
3. Have you ever had a severe allergic reaction that required treatment with Epinephrine or EpiPen, or caused you to go to the hospital, caused hives, swelling, or respiratory distress including wheezing? *Was the severe reaction after receiving a COVID-19 vaccine? *Was the severe reaction after receiving another vaccine or another injectable medication?			
4. Check all that apply to you: <input type="checkbox"/> Have a history of myocarditis or pericarditis <input type="checkbox"/> Have a history of Guillain-Barre Syndrome <input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum <input type="checkbox"/> Diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection <input type="checkbox"/> Have a weakened immune system (i.e., HIV infection, cancer) <input type="checkbox"/> Take immunosuppressive drugs or therapies <input type="checkbox"/> Have a bleeding disorder or take blood thinners <input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT) <input type="checkbox"/> Am currently pregnant or breastfeeding <input type="checkbox"/> Have received dermal fillers			

I have been given a copy and have read the Emergency Use Authorization (EUA) and reviewed the FDA Fact Sheet for Recipients and Caregivers for the COVID-19 vaccine product I will be administered (choose one of the following):
 _____ Pfizer (age 12 & over); _____ Moderna (age 18 and over); _____ Janssen (age 18 and over)

I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine indicated and ask that it 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 or Parent/Guardian Signature

FOR ADMINISTRATIVE USE ONLY							
Vaccine recipient provided:							
<input type="checkbox"/> Pfizer https://www.fda.gov/media/144414/download <input type="checkbox"/> Moderna https://www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-recipients.pdf <input type="checkbox"/> Janssen https://www.janssenlabels.com/emergency-use-authorization/Janssen+COVID-19+Vaccine-Recipient-fact-sheet.pdf <input type="checkbox"/> Other vaccine information statement(s) _____							

Vaccine	Dose	Route	Date Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
	_____ ml <input type="checkbox"/> 1 st _____ ml <input type="checkbox"/> 2 nd _____ ml <input type="checkbox"/> 3 rd	<input type="checkbox"/> IM - L Arm <input type="checkbox"/> IM - R Arm					

