COVID-19 VACCINE INFORMATION AND CONSENT FORM

Name: _____ _____ _____
First Middle Last

Address: _____ _____ _____ _____
Street City State Zip

Telephone: (_____) _____--_____ _____
Email

Date of Birth: _____--_____--_____	Age:	**Gender:** ☐Male ☐ Female	**Primary Language:** ☐ English ☐Other _____	**Ethnicity: (check only 1)** ☐ Not Hispanic ☐ Hispanic ☐ Unknown

Race: (check only 1) ☐Asian/Polynesian ☐Black ☐Multiracial ☐White ☐Native Am/Alaskan ☐Unknown

Please answer the health questions below:	**Yes**	**No**	**Don't Know**
1. Are you sick today or currently in an isolation period for COVID-19?			
2. Have you ever received a dose of COVID-19 vaccine? If yes, circle which one? Pfizer Moderna Janssen (J&J) other			
3. Have you ever had an allergic reaction (needing epinephrine or caused hives, swelling or wheezing) to:			
-Polyethylene glycol (PEG) in medicines such as laxatives or colonoscopy preps			
-Polysorbate, which is found in some vaccines, film coated tablets, and IV steroids			
-A previous dose of COVID-19 vaccine			
-A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but is not known which component gave the reaction			
4. Have you ever had an allergic reaction to another vaccine (other than a COVID-19 vaccine) or an injectable medicine?			
5. Have you ever had a severe allergic reaction after to something other than a vaccine like food, pet, venom, environmental, or oral medication?			
6. Have you received any vaccinations in the past two weeks?			
7. Have you ever had a positive COVID-19 test or has the doctor told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer, or do you take immunosuppressive drugs or therapies?			
10. Are you currently receiving anticoagulation therapy or do you have any type of bleeding disorder?			
11. Are you currently breastfeeding or pregnant?			
12. Do you have dermal fillers?			

I have been given a copy and have read, or have had explained to me, the information in the Vaccine Information Statements for the vaccines indicated. I have had the chance to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of the vaccines requested and ask that the vaccines indicated be given to me or the person named for whom I am authorized to make this request.

It is suggested that anyone getting a vaccine stay for 15 minutes after getting vaccinated before leaving.
Those with previous anaphylactic reactions should stay for 30 minutes.

_____ _____ **X**_____
Date **Print Name** **Patient/Guardian Signature**

OFFICE USE ONLY		**Record of Immunization**					**OFFICE USE ONLY**	
Vaccine	**Manf**	**Lot #**	**Exp**	**Dsg**	**Rte**	**Ste**	**Date**	**Nurse**