

COVID-19 Vaccine Adult Consent Form

Answer the following questions to help us safely give COVID-19 vaccine to you. Vaccines are provided at no cost to you.

Information			
Last name	First name	Middle Initial	Telephone number
Mailing address	City	State	Zip code
Birthdate	Age	Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Race (check all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Decline to answer	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Decline to answer	Sex assigned at birth <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender male <input type="checkbox"/> Transgender female <input type="checkbox"/> Genderqueer/non-binary <input type="checkbox"/> Other

Email address: _____

Signature
<p>I have received, read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian). I understand immunization information is entered into a database that is shared with other medical providers use.</p> <p>Print Parent/Guardian name, if different from patient: _____</p> <p>Patient/Parent/Guardian Signature: _____ Date: _____</p>

For office use only				
Dose <input type="checkbox"/> 0.3 ml IM <input type="checkbox"/> 0.5 ml IM <input type="checkbox"/> Other _____	Site <input type="checkbox"/> RA <input type="checkbox"/> LA <input type="checkbox"/> Other _____	Manufacturer	Lot #	Exp
Date EUA information sheet given	Date next dose due	Appointment made? <input type="checkbox"/> Yes <input type="checkbox"/> No		Appointment date
Signature of Medical Staff who gave injection and title			Date	

Prevaccination Checklist for COVID-19 Vaccines



For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.**

Name _____

Age _____

Yes No Don't know

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
<ul style="list-style-type: none"> If yes, which vaccine product did you receive? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another product _____ 			
3. Have you ever had an allergic reaction to:			
(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
<ul style="list-style-type: none"> A component of a COVID-19 vaccine including either of the following: <ul style="list-style-type: none"> <input type="checkbox"/> Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures <input type="checkbox"/> Polysorbate, which is found in some vaccines, film coated tablets, and intravenous 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 it is not known which component elicited the immediate reaction. 			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?			
(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as 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. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Do you have a history of or a risk factor for a blood clotting disorder?			
12. Are you pregnant or breastfeeding?			
13. Do you have dermal fillers?			

Form reviewed by _____

Date _____