COVID-19 VACCINE CONSENT FORM

FULL NAME (FIRST, MI, LAST)____

DATE OF BIRTH______________AGE:__________GENDER:M_____F______PHONE NUMBER______________

ADDRESS:___________________CITY:_______________________STATE:________ZIP CODE:____________

	YES	NO	DON'T KNOW
1. ARE YOU FEELING SICK TODAY?			
2. HAVE YOU EVER RECEIVED A DOSE OF COVID-19 VACCINE?			
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.)			
- POLYETHYLENE GLYCOL (PEG), WHICH IS FOUND IN SOME MEDICATIONS, SUCH AS LAXATIVES AND PREPARATIONS FOR COLONOSCOPY PROCEDURES			
- 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 IT IS NOT KNOWN WHICH COMPONENT ELICITED THE IMMEDIATE REACTION			
4.HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY VACCINE OR INJECTABLE MEDICATION?			
5. HAVE YOU EVER HAD A SEVERE ALLERGIC REACTION (E.G., ANAPHYLAXIS) TO SOMETHING OTHER THAN A COMPONENT OF COVIDE-19 VACCINE, OR ANY VACCINE OR INJECTABLE MEDICATION? THIS WOULD INCLUDE FOOD, PET, VENOM, ENVIRONMENTAL, ORAL MEDICATION, OR LATEX 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. ARE YOU PREGNANT OR BREASTFEEDING?			
12. DO YOU HAVE DERMAL FILLERS?			

Signature for Consent

I understand the benefits and risks of vaccination as described in the Vaccine Information Statement (VIS), a copy of which was provided with this Consent. I request the vaccine be given to me or the person named above, a minor for whom I represent that I am authorized to sign this Consent. I request that payment of authorized Medicare/Medicaid and/or private insurance benefits for immunizations listed below be made on my behalf to the carter's Family Pharmacy.

Signature of Person to receive vaccine (or Parent/Guardian, if Recipient is a Minor): ________________________________

PRINT PARENT/GUARDAIN NAME AND PHONE # (if Recipient is a Minor)____________________________**Date:**__________

DATE ADMINISTERED	VACCINE LOT#	EXP DATE	MFR	DOSAGE	INJ SITE	PHARMACSIST
	042A21A	12/31/2069	J&J	0.5ML		