# COVID19 Vaccine Consent Form

Name (Last, First): ______________________________ Date of Birth: ___________________
Gender: o Female o Male o Other Social Security Number: ___________________
Address: _________________________________________ City: ________________________
State: _______________ Zip Code: ____________ Phone Number: _______________________
Do you have a Family Care Doctor? o Yes o No Family Doctor Name: ________________
Emergency Contact Name, Relation, Phone Number:

_____________________________________________________________________________

Is this your second dose of the COVID-19 vaccine?

o Yes o No

If so, date of first dose? (MM/DD/YYYY): __________________________

Are you feeling sick at all today? o Yes o No

Have you ever had an allergic reaction to any medications or immunizations?

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. Itwould also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing)

- A component of the COVID-19 vaccine, including polyethylene glycol (PEG) or polysorbate?
  - o Yes o No
- A previous dose of COVID-19 Vaccine
  - o Yes o No

Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than acomponent of COVID-19 vaccine or any vaccine or injectable medication?

This would include food, pet, environmental, or oral medication allergies.

o Yes o No o Don't know

Have you received any vaccine in the last 14 days?

o Yes o No o Don't know

Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?

o Yes o No o Don't know

Do you have a bleeding disorder or are you taking a blood thinner?

o Yes o No o Don't know

Are you pregnant or breastfeeding?

o Yes o No o Don't know

Consent (initial each line below after reading):

I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet, a copy of which I was provided with this Consent Form. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign the Consent Form. ______

I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur. ______

I understand that I will be receiving the vaccination at no cost to me. ______

Signature of Person to Receive Vaccine & EUA/VIS: ________________________ Date: ___________