

SARS-COV-2 Vaccine Consent & Administration Form

PATIENT FIRST NAME	PATIENT LAST NAME	
DATE OF BIRTH	PHONE NUMBER	
ADDRESS		
EMAIL ADDRESS:		
SCREENING QUESTIONNAIRE	YES	NO
Have you ever received a COVID-19 vaccine? If yes, date: _____ Type/Brand of COVID vaccine: _____		
In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?		
Have you received passive antibody therapy as treatment for COVID-19 in the last 90 days?		
Have you received any other vaccines in the last 14 days?		
Have you ever had a serious reaction (anaphylaxis) to vaccine, injectable medication, food or other?		
Are you sick now with a moderate or severe illness?		
Are pregnant or breast feeding?		
Are you on blood thinners?		

CONSENT

- I have been given a copy and have read, or have had explained to me, the information in the FACT SHEET for the COVID-19 vaccine. I understand the FDA has authorized emergency use of the COVID-19 vaccine, which is not an FDA-approved vaccine. I have had the chance to ask questions that were answered to my satisfaction.
- I have been advised to wait for 15-30 minutes for observation after receiving my vaccine. If I experience a severe reaction while under observation, I understand that 911 will be called.
- I understand that I am fully responsible for complying with any restrictions prescribed for me by my personal physician. I have discussed the safety of COVID-19 vaccine if I have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system and/or take any medications that affect my immune system.
- I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- I understand the significant known and potential risks and benefits of the COVID-19 vaccine as explained in the FACT SHEET and that some potential risks and benefits may remain unknown.
- I request that the COVID-19 VACCINE be given to me or to the person listed above, for whom I certify that I am authorized to make this request and consent on their behalf.

Patient / Patient Agent (Signature)

Date

Print Name, if other than Patient

Date	Vaccine Name	Administration	Route: IM	Dose	Manufacturer & Lot	Expiration
	<input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna	<input type="checkbox"/> First Dose <input type="checkbox"/> Second Dose	<input type="checkbox"/> R Deltoid <input type="checkbox"/> L Deltoid	<input type="checkbox"/> 0.3ml <input type="checkbox"/> 0.5ml		

I have provided the patient (and/or agent or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

Vaccinator Signature: _____ **Vaccinator Employee ID:** _____