Logo

Description automatically generated

**COVID-19 Vaccine**

**INFORMATION AND CONSENT FORM**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **NAME** (Last) | | (First) | | Date of Birth:  \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ | | **Age:** | |
| **ADDRESS** | | | | | | | |
| **CITY** | **STATE** | **ZIP** | | **DAYTIME PHONE NUMBER** | | | |
| **EMERGENCY CONTACT: Name Relation Phone Number** | | | | | | | |
| **Race: (check only 1)**  Asian/Polynesian Black Multiracial Native Am/Alaskan White Unknown | | | **Ethnicity: (check only 1)**   Not Hispanic   Hispanic Unknown | | **Primary Language:**   English  Other \_\_\_\_\_\_\_\_\_\_\_ | | **Gender:**  Male   Female |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please answer the health questions below:** | **Yes** | **No** | **Do Not Know** |
| 1. Are you feeling sick today? |  |  |  |
| 2. Have you ever received a dose of COVID-19 vaccine?  \*If yes, which vaccine product:  Pfizer  Moderna Janssen  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 3. Have you ever had a severe allergic reaction that required treatment with Epinephrine or EpiPen, or caused you to go to the hospital, caused hives, swelling, or respiratory distress including wheezing? |  |  |  |
| \*Was the severe reaction after receiving a COVID-19 vaccine? |  |  |  |
| \*Was the severe reaction after receiving another vaccine or another injectable medication? |  |  |  |
| 4. Check all that apply to you:  Have a history of myocarditis or pericarditis  Have a history of Guillain-Barre Syndrome  Had COVID-19 and was treated with monoclonal antibodies or convalescent serum  Diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection  Have a weakened immune system (i.e., HIV infection, cancer)  Take immunosuppressive drugs or therapies  Have a bleeding disorder or take blood thinners  Have a history of heparin-induced thrombocytopenia (HIT)  Am currently pregnant or breastfeeding  Have received dermal fillers | | | |

|  |
| --- |
| I have been given a copy and have read the Emergency Use Authorization (EUA) and reviewed the FDA Fact Sheet for Recipients and Caregivers for the COVID-19 vaccine product I will be administered (choose one of the following):  \_\_\_\_\_\_ Pfizer (age 12 & over); \_\_\_\_\_ Moderna (age 18 and over); \_\_\_\_\_ Janssen (age 18 and over)  I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine indicated and ask that it be given to me, or the person named for whom I am authorized to make this request.  **My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine.**  **Those with previous anaphylactic reactions should stay for 30 minutes** \_\_\_\_\_\_\_\_\_\_\_\_\_  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date Print Name Patient or Parent/Guardian** **Signature** |
| **FOR ADMINISTRATIVE USE ONLY**  **Vaccine recipient provided:**   Pfizer <https://www.fda.gov/media/144414/download>   Moderna <https://www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-recipients.pdf>   Janssen <https://www.janssenlabels.com/emergency-use-authorization/Janssen+COVID-19+Vaccine-Recipient-fact-sheet.pdf>    Other vaccine information statement(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |