

  **COVID-19 Vaccine**

 **INFORMATION AND CONSENT FORM**

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| **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 |

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| **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 |

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| 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](https://www.janssenlabels.com/emergency-use-authorization/Janssen%2BCOVID-19%2BVaccine-Recipient-fact-sheet.pdf)   Other vaccine information statement(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |