



COVID-19 VACCINE CONSENT FORM

Information about person to receive vaccine (please print)

Name: _____ Birth date: ___/___/___ Age: _____ Sex: Male Female

Race: Asian Black Native American Pacific Islander White Other Ethnicity: Hispanic Non-Hispanic

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Do you have insurance? No Yes

The following questions will help determine if there is any reason you should not receive a COVID immunization injection.

Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.

Has the person to be vaccinated ever received a COVID-19 vaccine?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
If yes, date: _____ Type/Brand of COVID vaccine: _____		
Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
List all allergies: _____		
Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Is the person to be vaccinated sick today?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Is the person to be vaccinated at least 18 years old?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
If no, is the person to be vaccinated at least 16 years old?		
Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Has the person to be vaccinated received any other vaccines in the past 14 days?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

I have read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian).

I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

Print Parent/Guardian name, if different from client: _____

Client/Parent/Guardian Signature: _____ Date: _____

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Clinic site: HB Pharmacy EUA Fact Sheet Provided: Yes No

Date vaccine administered: ___/___/___ Date booster required: ___/___/___

Vaccine manufacturer: Moderna Bivalent Lot number: _____

Site of IM injection: RDT or LDT or _____ Dose: 0.3ml 0.5ml

Signature and title of vaccine administrator: _____

Comments: _____

Prevaccination Checklist for COVID-19 Vaccination



Name _____

For vaccine recipients (both children and adults):

The following questions will help us determine if there is any reason COVID-19 vaccine cannot be given today.

If you answer "yes" to any question, it does not necessarily mean the vaccine cannot be given. It just means additional questions may be asked. If a question is not clear, please ask the healthcare provider to explain it.

	Yes	No	Don't know
1. How old is the person to be vaccinated? _____			
2. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever received a dose of COVID-19 vaccine? • If yes, which vaccine product was administered? <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Janssen (<i>Johnson & Johnson</i>) <input type="checkbox"/> Another Product <input type="checkbox"/> Moderna <input type="checkbox"/> Novavax _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• How many doses of COVID-19 vaccine were administered? _____			
• Did you bring the vaccination record card or other documentation?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Is the person to be vaccinated have a health condition or undergoing treatment that makes them moderately or severely immunocompromised? <i>This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the person to be vaccinated received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the person to be vaccinated ever had an allergic reaction to: <i>(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 caused hives, swelling, or respiratory distress, including wheezing.)</i>			
• A component of a COVID-19 vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• A previous dose of COVID-19 vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the person to be vaccinated ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? <i>(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 caused hives, swelling, or respiratory distress, including wheezing.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Check all that apply to the person to be vaccinated:			
<input type="checkbox"/> Have a history of myocarditis or pericarditis			
<input type="checkbox"/> Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?			
<input type="checkbox"/> History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)			
<input type="checkbox"/> Have a history of thrombosis with thrombocytopenia syndrome (TTS)			
<input type="checkbox"/> Have a history of Guillain-Barré Syndrome (GBS)			
<input type="checkbox"/> Have a history of COVID-19 disease within the past 3 months?			
<input type="checkbox"/> Vaccinated with monkeypox vaccine in the last 4 weeks?			

Form reviewed by _____

Date _____