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?	☐ No ☐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?	☐ No ☐Yes
List all allergies: _____	
Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy?	☐ No ☐Yes
Is the person to be vaccinated sick today?	☐ No ☐Yes
Is the person to be vaccinated at least 18 years old?	☐ No ☐Yes
If no, is the person to be vaccinated at least 16 years old?	☐ No ☐Yes
Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner?	☐ No ☐Yes
Has the person to be vaccinated received any other vaccines in the past 14 days?	☐ No ☐Yes
Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19?	☐ No ☐ 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: _____

FOR CLINIC USE ONLY

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:*** *0.25ml 0.5ml*

Signature and title of vaccine administrator: _____

Comments: _____

Prevaccination Checklist for COVID-19 Vaccination

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Name _____

Age _____

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product(s) did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	☐	☐	
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)*	☐	☐	☐
4. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	☐	☐	☐
5. Have you ever had an allergic reaction to: *(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.)*			
• A component of a COVID-19 vaccine, including either of the following:			
o Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
o Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
6. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(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.)*	☐	☐	☐

7. Check all that apply to you:

- ☐ Am a male between ages 12 and 39 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of Guillain-Barré Syndrome (GBS)

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists