COVID-19 VACCINE CONSENT FORM

Print Name: _____ **Birth date**: _____/_____/_____

Home Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **County of Residence:**_____

Gender: ☐Male ☐Female **Ethnicity**: ☐Hispanic ☐Non-Hispanic

Race: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other

Do you have a fever (>100.4) or are you sick today?	☐ No ☐Yes
Have you ever had a severe allergic reaction to a vaccination?	☐ No ☐Yes
Are you pregnant or lactating, or plan to become pregnant in the next month?	☐ No ☐Yes
Do you have shortness of breath, dry cough, runny nose, sore throat, muscle pain or loss of taste or smell?	☐ No ☐Yes
Are you taking antiviral medication?	☐ No ☐Yes
Have you received any other vaccinations in the past two weeks?	☐ No ☐Yes
Do you have long-term health problems such as heart disease, lung disease, kidney disease metabolic disease such as diabetes, asthma, neurologic or neuromuscular disease or anemia or another blood disorder?	☐ No ☐Yes
Do you have a weakened immune system because of HIV/AIDS or any other disease that attacks the immune system, long term treatment with drugs such as high dose steroids or cancer treatment with radiation or drugs?	☐ No ☐Yes

I have been provided the Fact Sheet for Recipients and Caregivers Emergency Use Authorization (EUA) of the COVID-19 vaccine. I appreciate that it is not possible to consider every possible complication to the vaccination. I have had the opportunity to ask questions about this vaccination. I believe I understand this information, and my questions have been answered to my satisfaction. I understand any specific concerns about my health should be directed to my Primary Care Provider. I understand the benefits and risks of the COVID-19 vaccine and request the vaccine be given to me.

Signature: _____ Date: _____

FOR ADMINISTRATIVE USE ONLY

VACCINE	DATE DOSE ADMINISTERED	ROUTE	SITE	VACCINE MANUFACTUER	LOT NUMBER/ EXP. DATE	NAME/TITLE OF VACCINE ADMIN.
COVID-19		**IM DELTOID**	**LT / RT**	**MODERNA**		