COVID-19 VACCINE CONSENT & ADMINISTRATION FORM FOR PATIENTS

Patient Name (Print Clearly): _____ DOB: _____/_____/_____ Age:_____

H□□Address: _____ City:_ _____ State:_____ Zip:_____

Phone Number: (_____) _____-_____ Primary Care Physician Name: _____

VOLUNTARY CONSENT TO COVID-19 VACCINE:

I understand that COVID-19 can have serious, life-threatening complications (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html), and there is no way to know how COVID-19 will affect me. I further understand that a COVID-19 vaccine may help keep me from becoming seriously ill, even if I do become infected with COVID-19.

I have reviewed my specific vaccine EUA Fact Sheet or have had its contents including the benefits, the usual and most frequent risks of receiving this vaccine, and alternatives explained to me, based upon currently available information. Depending upon the COVID-19 vaccine that I receive, I may require one or two injections. I have had an opportunity to ask questions which have been answered to my satisfaction. I agree to remain at the vaccination location for at least 15 minutes after vaccine is administered in the event of adverse reaction.

I understand that:

- This vaccine is authorized for use under Emergency Use Authorization (EUA) issued by the U.S. Food and Drug Administration (FDA). Under an EUA, the FDA may allow the use of unapproved medical products, or unapproved uses of approved medical products, in an emergency to diagnose, treat, or prevent serious or life-threatening diseases or conditions when certain statutory criteria have been met, including that there are no adequate, approved, and available alternatives.
- It is unclear how long any potential benefits of the vaccine may last. Additional research is needed to answer this question.
- Receiving this vaccine does not eliminate the need for masking, social distancing, and hand hygiene.
- I may still become ill with COVID-19 and may be able to transmit the virus to other individuals.
- This vaccine has not been studied on individuals who are pregnant or breastfeeding and it is recommended that I discuss vaccination with my provider prior to receiving vaccine.

I understand and acknowledge record of this vaccine administration to me will be reported to the state and/or federal regulatory bodies in compliance with reporting for inventory management and use of National Stockpile vaccine supply. I agree and authorize my COVID-19 vaccine record to be shared with my primary care physician and included in my health record(s) for continuity of care of care purposes. I further agree and authorize my COVID-19 vaccine record to be shared for quality of care, patient safety, and other research purposes.

☐ **I acknowledge this information and consent to receiving the COVID-19 vaccine series.**

Precautions/Contraindications: (Vaccine may not be administered depending on your responses)

Fever or feeling ill today?	☐ No	☐ Yes – Defer until feeling better.
Have you ever received a dose of COVID-19 vaccine?	☐ No	☐ Yes – Ensure same vaccine and appropriate interval
History of severe allergic reaction (e.g., anaphylaxis) to any component of this vaccine?	☐ No	☐ Yes – STOP. Do NOT vaccinate.
History of severe allergic reaction (e.g., anaphylaxis) to another vaccine (not including this vaccine)?	☐ No	☐ Yes – Defer – consult with your primary care provider.
History of severe allergic reaction (e.g., anaphylaxis) to an injectable therapy?	☐ No	☐ Yes – Defer – consult with your primary care provider.
History of other serious allergic reaction (e.g., anaphylaxis) due to any cause	☐ No	☐ Yes – Requires 30 min observation.
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐ No	☐ Yes – STOP. Do NOT vaccinate for 90 days from last treatment date.
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐ No	☐ Yes – Defer – consult with your primary care provider.
Are you pregnant or breastfeeding?	☐ No	☐ Yes – Defer – consult with your primary care provider.

Today's Date: _____/_____/_____ Patient Name (Print): _____
Patient / Parent / Guardian Signature; *if parent / guardian, please also print name*
DOB: _____/_____/_____

----------STOP: FOR INTERNAL USE ONLY----------

Identity confirmed by: ☐ Driver's license ☐ Other Form of ID: _____

☐ Dose 1 of 2 administered	☐ Dose 2 of 2 administered (series complete)	☐ Dose 1 of 1 administered (series complete)
Vaccine Manufacturer: Lot #: Expiration Date:	Intramuscular Injection Given: ☐ Left Deltoid ☐ Right Deltoid	
Administered By (Full name and Title):	Date of Vaccine:	
☐ Pfizer EUA Given to Patient	☐ Moderna EUA Given to Patient	☐ J&J EUA Given to Patient