# COVID-19 Vaccination Consent Form 2020-2021

| Last Name *(Please print)* | First Name | MI | Date of Birth | ☐ Male ☐ Female | |
|---|---|---|---|---|---|
| Address | | City | | State | Zip |
| Phone Number | Email | | Name of Primary Care Provider | | |

## SCREENING FOR VACCINATION ELIGIBILITY

| | | |
|---|---|---|
| 1. Are you pregnant? | Yes | No |
| 2. Are you currently breastfeeding? | Yes | No |
| 3. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause? | Yes | No |
| 4. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of a COVID-19 vaccine, including lipid nanoparticles or polyethylene glycol (PEG)? | Yes | No |
| 5. Have you received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next 14 days? | Yes | No |
| 6. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days? | Yes | No |
| 7. Are you under age 16? | Yes | No |
| 8. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.? | Yes | No |
| 9. Do you have a bleeding disorder or are you taking a blood thinner? | Yes | No |
| 10. Have you tested positive for COVID-19 in the last 10 days? | Yes | No |
| 11. Are you currently in quarantine for COVID-19 exposure? | Yes | No |
| 12. If this is your second dose, when was the date of your first dose? | / / | |
| 13. If this is your second dose, which vaccine did you receive (Pfizer, Moderna, etc.)? | | |

## CONSENT FOR VACCINATION

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization Fact Sheet provided to me today. I understand the benefits and risks of the vaccine.

The vaccine checked above should be given to the person named above for whom I am authorized to make this request. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

Signature of Parent/Guardian/Patient_____Date_____