COVID-19 CONSENT

NAME: _____ Date of Birth: ___ /___ / _____

Address: _____ **City**: _____ **State**: ___

Zip: _____ **Phone**: _____

Do you have insurance? ☐ No ☐ Yes

Gender: ☐ Male ☐ Female ☐ Prefer not to say

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

Ethnicity: ☐Hispanic ☐Non-Hispanic

Screening Questions	
Are you sick today?	☐ Yes ☐ No
Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy?	☐ Yes ☐ No
Have you ever had an anaphylactic or a very bad allergic reaction after getting a vaccine or drug? (reactions such as trouble breathing, hives, facial or tongue swelling or low blood pressure)	☐ Yes ☐ No
Are you immune-compromised or take any medications that affects your immune system?	☐ Yes ☐ No
Has the person to be vaccinated received any other vaccines in the past 14 days?	☐ Yes ☐ No
Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19?	☐ Yes ☐ No
Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner?	☐ Yes ☐ No

Documentation

Vaccine ☐ **Pfizer**

Date vaccine administered: ____/____/_____ ***Booster required***:*Yes or No*

Lot number: _____ ***Site of IM injection***:*RDT or LD or* _____ ***Dose***: *0.3ml 0.5ml*

Signature administrator:_____

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Consent

I, the undersigned, give my consent to receive a COVID-19 vaccination offered at no cost to me. I understand that occasionally some of the following symptoms may occur following the administration of this vaccine:

- Soreness at the injection site for 1-2 days
- Fever, tiredness, headache, fever, chills, joint aches, muscle aches for 2 -3 days.
- Slight redness and swelling at the site of injection
- Swelling of lymph nodes (less common)
- Acute allergic reaction (rare)

I understand that I will receive either a one dose vaccine or a 2-dose series separated by 21-28 days. The COVID-19 vaccine should be completed with the same product. I have received a copy of the Emergency Use Authorization (EUA) from the FDA. Based upon this information, I have had the opportunity to ask questions which have been answered to my satisfaction and I understand the benefits and risks of COVID vaccination. Furthermore, I have read the above information and am not aware of any reasons that prohibit me from receiving the vaccine.

I, the undersigned, do hereby consent to allow the Advanced Practice Nurse, nurses, and/or authorized health care providers partnering with Health4Chicago, University of Chicago Medical Center, CDPH volunteers and University of Chicago Medical Clinic (UCMC) to administer the vaccine to me. All the UCMC staff providing my care at this clinic are volunteers and receive no fees or compensation of any kind for proving my care. Under the Illinois Good Samaritan law, the UCMC staff are not liable for civil damages as a result any negligent act or omission providing my care.

Patient/Parent Signature:_____

Date: _____

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