COVID-19 Vaccine
Adult Consent Form

Tacoma-Pierce County Health Department
Healthy People in Healthy Communities

Answer the following questions to help us safely give you COVID-19 vaccine. Vaccines are at no cost to you.

Information			
Last name	**First name**	**Middle initial**	**Telephone number**
Mailing address	**City**	**State**	**Zip code**

Email address	**Birthdate**	**Age**	**Do you have health insurance?**
			☐ Yes ☐ No

Race (check all that apply)	**Ethnicity**	**Sex assigned at birth**	**Gender identity**
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other_____ ☐ Decline to answer	☐ Hispanic ☐ Not Hispanic ☐ Decline to answer	☐ Female ☐ Male	☐ Male ☐ Female ☐ Transgender male ☐ Transgender female ☐ Genderqueer/non-binary ☐ Other_____

Signature

I have received, read/had explained to me, and understand the COVID-19 vaccine emergency use authorization (EUA) information sheet. I understand the benefits and risks of COVID-19 vaccine, and I choose to receive the vaccine.
I understand my immunization information will go into a database other medical providers use.

_____ _____
Signature **Date**

For office use only				
Dose ☐ 0.5 ml IM ☐ _____	**Site** ☐ RA ☐ LA	**Manufacturer**	**Lot #**	**Exp**

Date EUA info sheet given	**Date EUA published**	**Appointment?** ☐ Yes ☐ No	**Appointment date**

Vaccinator name (printed)	**Vaccinator signature**	**Date**

Prevaccination Checklist for COVID-19 Vaccines

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 _____

Birthdate _____

	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 did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product _____			
3. 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of a COVID-19 vaccine including either of the following:			
○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
• A previous dose of COVID-19 vaccine.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Do you have a history of or a risk factor for a blood clotting disorder?			
12. Are you pregnant or breastfeeding?			
13. Do you have dermal fillers?			

Form reviewed by _____ **Date** _____

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