COVID-19 Vaccine Consent Form

PATIENT INFORMATION				
Patient's **LEGAL** Last Name:	Patient's **LEGAL** First Name:	Phone Number:	Age:	Birthdate:
Street Address:	City:	County:	State:	Zip Code:

Assigned sex at birth:
☐ Female ☐ Male

Are you Hispanic or Latino
☐ Yes ☐ No

Race: (Select one or more)
☐ AS-Asian/Pacific Islander/Other ☐ BL-Black or African American ☐ CH-Chinese
☐ CA-Caucasian (White)/Mexican/Puerto Rican ☐ FI-Filipino ☐ HA-Hawaiian
☐ IN-Native American/Alaska Native ☐ JA-Japanese
☐ NW-Other Non-White ☐ UN-Unknown

Insurance Company or Medicare:	ID#:	Group# (Insurance Only):	Primary Physician:

VACCINATION SCREENING QUESTIONNAIRE	
1. Are you currently sick or experiencing a high fever?	☐ Yes ☐ No
2. Have you had a life threatening allergic reaction to any vaccine or other injection in the past?	☐ Yes ☐ No
3. Do you have any allergies to Benadryl, solumedrol, epinephrine, polysorbate, Polyethylene glycol, or prior COVID-19 vaccine? Please list:	☐ Yes ☐ No
4. Have you received any other vaccine in the past 14 days? List:	☐ Yes ☐ No
5. Have you been diagnosed with COVID-19 in the past 90 days? If yes, did you receive passive antibody therapy or plasma as part of their treatment? ☐ Yes ☐ No	☐ Yes ☐ No
6. In the past 3 months, have you taken medications that weaken their immune system, such as cortisone, Prednisone, other steroids, or anti-cancer drugs, or had radiation treatments?	☐ Yes ☐ No
7. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐ Yes ☐ No
8. Do you have a health problem with lung, heart, kidney, diabetes, asthma, thrombosis-thrombocytopenia syndrome (TTS), a blood or bleeding disorder, or on a blood thinner? Circle any medical condition that applies to you.	☐ Yes ☐ No
9. Are you breastfeeding?	☐ Yes ☐ No ☐ N/A
10. Are you pregnant or have a chance of becoming pregnant within the next month?	☐ Yes ☐ No ☐ N/A
11. Have you previously received a COVID-19 vaccine? ☐ Yes ☐ No If yes, please select: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ☐ Other: Date:	
12. Have you had an adverse reaction to any COVID-19 vaccine? ☐ Yes ☐ No ☐ N/A	
13. If you answered yes to #12, did the adverse reaction require emergency medical attention?	☐ Yes ☐ No ☐ N/A

Please read and check each of the following statements then sign.

☐ I have been offered a copy of the Vaccine Fact Sheet EUA for the COVID-19 vaccine checked below, whether accepted or not. I have read or had explained to me the information in the Fact Sheet, including the possible adverse reactions, the components of the vaccine, the possible risks, and what to do after the vaccination.

☐ I ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I consent to the inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the above named person.

☐ *I understand the importance of remaining in the clinic for 15 minutes after I/person named above receive(s) this vaccine. I understand that there is an increased risk of allergic reactions and syncopal episodes within the first 15 minutes after a vaccination, and if I/person named above choose to leave the facility, I assume responsibility for this risk.*

☐ If the person named above is a minor, I do hereby solemnly swear that I have legal custody of the aforementioned minor. I grant authorization and consent for Saline County Vaccination Collaboration to administer the COVID-19 vaccine to the above named minor and provide medical evaluation and treatment throughout the vaccine process, including administration of medications and calling EMS for transport to the nearest emergency department.

Signature of Patient or Parent/Guardian:_____ **Date:** _____

Staff use only:

VACCINE	*DOSE*	*EXT*	*SITE*	*ROUTE*	*MANUFACTURER LOT #*	*EXP DATE*
Moderna	**0.5 ml. 1 2**	**RT LT**	**Deltoid Vastus Lat**	**IM**	**Moderna**	
Pfizer	**0.3 ml. 1 2**	**RT LT**	**Deltoid Vastus Lat**	**IM**	**Pfizer**	
J & J	**0.5 ml. 1**	**RT LT**	**Deltoid Vastus Lat**	**IM**	**Janssen**	

Signature and Title of Vaccine Administrator _____ **Date Given** _____