COVID-19 Vaccine Administration Consent/Record

Section 1: Vaccine Recipient Information

Name: _____ _____ _____
Last First M.I.

Address: _____
Street City State Postal Code

Date of Birth: _____ Age:_____ Gender: ☐ Male ☐ Female

Primary Healthcare Provider: _____

Cell Phone Number: (_____) _____

Section 2: Screening for Vaccine Eligibility

Has the person listed above previously received COVID-19 vaccine? ☐ Yes ☐ No

If yes to above, indicate the COVID-19 vaccine previously received:
Vaccine Brand Administered (Pfizer, Moderna, Astra Zeneca, Johnson and Johnson):

Date first dose administered: Month _____ Day _____ Year _____

Date second does administered: Month _____ Day _____ Year _____

Section 4:

Consent I have read or have had explained to me the information provided in the Emergency Use Authorization (EUA) Factsheet or Vaccine Information Statement about COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be administered to me or to the person named above for whom I am authorized to make this request.

Signature:_____ Date: _____

Healthcare Provider Use Only

Date Vaccine #1 Administered: _____ **Injection Site (Deltoid):** ☐ **Left** ☐ **Right**

MFG/LOT#

Administered by Print: _____ **Signature:** _____

Date Vaccine #2 Administered: _____ **Injection Site (Deltoid):** ☐ **Left** ☐ **Right**

MFG/LOT#

Administered by Print: _____ **Signature:** _____

COVID-19 Vaccine EUA FACT SHEET for Recipients provided COVID-19 Pre-Vaccination Form (screening form) completed for the vaccine to be provided

#1 Date entered in IRIS:	**#2** Date entered in IRIS:
_____	_____
Initials: _____	Initials: _____

Print Patient Name _____ Age _____

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 any "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.

	For Dose #1				For Dose #2		
	YES	NO	Don't Know		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? ☐ Moderna ☐ Pfizer ☐ Another product _____							
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?							
Was the severe allergic reaction after receiving a COVID-19 vaccine?							
Was the severe allergic reaction after receiving another vaccine or another injectable medication?							
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19? **Vaccination should be deferred for at least 90 days**							
5. Have you received another vaccine in the last 14 days?							
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?							
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?							
8. Do you have a bleeding disorder or are you taking a blood thinner?							
9. Are you pregnant or breastfeeding?							

Dose # 1 Form Reviewed by: _____ Date: _____

Dose # 2 Form Reviewed by: _____ Date: _____