COVID-19 Vaccine Administration Consent/Record

Vaccine Recipient Information

Name: ______________________ ______________________ ____
Last First M.I.

Address: ____
Street City State Zip code

Date of Birth: ________________ Age:______ Gender: ☐ Male ☐ Female

Primary Physician Name: ______________________________

Cell Phone Number: (______) ________________

Email Address: ______________________________

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**: ______________

VACCINE to be administered:

☐ MODERNA ☐ Johnson & Johnson ☐ PFIZER ☐ Other (list)____________

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:** ______________________

Date first dose administered: Month ____________ Day ______ Year ________

Date second does administered: Month ____________ Day ______ Year ________

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: _____

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Name ______________________

Age ______________

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.

	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 ______			
• Did you bring your vaccination record card or other documentation? *(yes/no)*	☐	☐	
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 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	☐	☐	☐
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 caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

5. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré Syndrome (GBS)

Form reviewed by ______________________ **Date** ______________