**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**

**Phone Number: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Vaccine #2 Administered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injection Site (Deltoid):  Left  Right**

**MFG/LOT#**

**Administered by Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Vaccine #3 or BOOST Administered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injection Site (Deltoid):  Left  Right**

**MFG/LOT# (Moderna ONLY) 0.25 0.5**

**Administered by Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**VACCINE to be administered:**

** MODERNA  Johnson & Johnson  PFIZER  Another Product \_\_\_\_\_\_\_\_\_\_\_\_\_**

COVID-19 Vaccine EUA FACT SHEET for Recipients provided COVID-19 Pre-Vaccination Form

(Screening form) completed for the vaccine to be provided FOR VACCINE RECIPIENTS:

**# 1** Date entered in IRIS: \_\_\_\_\_\_\_\_\_\_\_\_ **# 2** Date entered in IRIS: \_\_\_\_\_\_\_\_\_\_\_\_\_ **# 3 / BOOST** Date entered in IRIS: \_\_\_\_\_\_\_\_\_\_\_\_\_

Initials: \_\_\_\_\_\_ Initials: \_\_\_\_\_\_ Initials: \_\_\_\_\_\_

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.

DOSE **#1** DOSE **#2** DOSE **#3/Boost**

**Yes No Don’t Yes No Don’t Yes No Don’t**

**Know Know 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 Johnson & Johnson Another Product |  |  |  |  |  |  |  |  |  |  |  |
|  | **Have you received a COMPLETE Covid-19 series?**  (i.e., 1 dose Janssen or 2 doses of an mRNA vaccine (Pfizer-BioNTech, Moderna) |  |  |  |  |  |  |  |  |  |  |  |
|  | **Did you bring your vaccination record card or other documentation?** |  |  |  |  |  |  |  |  |  |  |  |
| 3 | **Have you ever had a severe allergic reaction to:**  This would include a severe reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include a allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) |  |  |  |  |  |  |  |  |  |  |  |
|  | ***A component of a COVID 19vaccine 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 reaction for which you were treated with epinephrine or EpiPen, or 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.) |  |  |  |  |  |  |  |  |  |  |  |
|  | *\*\*\** ***Check all that apply*** *\*\*\** |  |  |  |  |  |  |  |  |  |  |  |
|  | Am a Female between ages 18-49 years old |  |  |  |  |  |  |  |  |  |  |  |
|  | Am a Male between ages 12-29 |  |  |  |  |  |  |  |  |  |  |  |
|  | 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 |  |  |  |  |  |  |  |  |  |  |  |
|  | Had COVID 19 and *treated with* monoclonal antibodies or convalescent serum |  |  |  |  |  |  |  |  |  |  |  |
|  | Diagnosed with Multi-system Inflammatory Syndrome  (MIS-C OR MIS-A) after a covid |  |  |  |  |  |  |  |  |  |  |  |
|  | Have a weakened immune system  (i.e – HIV, 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 breast feeding |  |  |  |  |  |  |  |  |  |  |  |
|  | Have received dermal fillers |  |  |  |  |  |  |  |  |  |  |  |
|  | History of Guillain-Barre Syndrome (GBS) |  |  |  |  |  |  |  |  |  |  |  |

***Dose Form Reviewed by***  Initials: \_\_\_\_\_\_ Initials: \_\_\_\_\_\_ Initials: \_\_\_\_\_\_

Print Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_

**UPDATED: 8-20-21**