# COVID-19 VACCINE CONSENT FORM

**Last Name:**_____ **First Name:**_____ **Middle:** _____

**Address:**_____ **City:**_____ **Zip:** _____

**Phone:**_____ **Male:** ☐ **Female:** ☐ **Other:** ☐ **Date of Birth:**____/____/_____ **Age:** _____

**Race (check all that apply):** ☐ **American Indian/Alaskan Native** ☐ **Asian** ☐ **White** ☐ **Other**

☐ **African American/Black** ☐ **Native Hawaiian/Pacific Islander**

**Ethnicity: Hispanic?** ☐ **Yes** ☐ **No** ☐ **Unknown** ☐ **Decline**

## COVID-19 VACCINATION SCREENING

| | | | |
|---|---|---|---|
| **1.** | **Do you have a fever today or are you feeling ill?** | **Yes** ☐ | **No** ☐ |
| **2.** | **Have you ever received a dose of COVID-19 vaccine?**<br>**If yes, which vaccine product?**<br>**Pfizer** ☐ **Moderna** ☐ **Another product** | **Yes** ☐ | **No** ☐ |
| **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?** | **Yes** ☐ | **No** ☐ |
| **4.** | **Was the severe allergic reaction after receiving a COVID-19 vaccine?** | **Yes** ☐ | **No** ☐ |
| **5.** | **Was the severe allergic reaction after receiving another vaccine or another injectable medication?** | **Yes** ☐ | **No** ☐ |
| **6.** | **Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?** | **Yes** ☐ | **No** ☐ |
| **7.** | **Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? Date**_____ | **Yes** ☐ | **No** ☐ |
| **8.** | **Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?** | **Yes** ☐ | **No** ☐ |
| **9.** | **Do you have a bleeding disorder or are you taking a blood thinner?** | **Yes** ☐ | **No** ☐ |
| **10.** | **Are you pregnant or breastfeeding?** | **Yes** ☐ | **No** ☐ |

☐ I have received this clinic's HIPAA Notice of Privacy Practices information sheet.

☐ I have received and read the EMERGENCY USE AUTHORIZATION (EUA) on the COVID-19 Vaccine to be given. I am aware that some people may experience physical responses to the injection; such as (but not limited to) injection site pain, light-headedness or fainting. I understand the benefits and risks and request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

☐ I am aware I am required to wait 15 minutes after my injection to be observed for a vaccine reaction.

Client/Parent Signature:_____ Date: _____

Client Name_____Date of Birth_____

## YCPH OFFICE USE ONLY

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| COVID-19 Brand: | Dose Amt: | Lot # Exp. |
|---|---|---|
| | | Injection Site: R ☐ L ☐ DELTOID ☐ |
| Dose #:<br>1 ☐ 2 ☐ 3 ☐<br>Booster #:<br>1 ☐ 2 ☐<br>*(Check One)* | | Client tolerated well?<br>Yes ☐ No ☐<br>*(Check One)*<br>Time Given:<br>15-minute wait done at: |

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Patient here for COVID vaccine. Patient given EUA handout, and all questions answered. Vaccine card given to patient.

**Vaccine Administrator Signature/ Title:** _____

**Date:** _____

**2nd Vaccine Administrator Signature/ Title:** _____

**Date:** _____