COVID-19 Vaccine Consent Form

Clinic name_____

☐ 1st dose ☐ child 5-11 years old
☐ 2nd dose
☐ 3rd or booster dose

Answer the following questions to help us safely give you COVID-19 vaccine. Vaccines are at no cost to you.

Information			
Last name	**First name**	**Middle initial**	**Telephone number**
Mailing address	**City**	**State**	**Zip code**

Email address	**Birthdate**	**Age**	**Do you have health insurance?**
			☐ Yes ☐ No

Race (check all that apply)	**Ethnicity**	**Sex assigned at birth**	**Gender identity**
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other_____ ☐ Decline to answer	☐ Hispanic ☐ Not Hispanic ☐ Decline to answer	☐ Female ☐ Male	☐ Male ☐ Female ☐ Transgender male ☐ Transgender female ☐ Genderqueer/non-binary ☐ Other_____

Patient/Parent or Guardian Signature

I have received, read/had explained to me, and understand the COVID-19 vaccine emergency use authorization (EUA) information sheet. I understand the benefits and risks of COVID-19 vaccine, and I choose to receive the vaccine.
I understand my immunization information will go into a database other medical providers use.

I received, read / explained to me, and understand the vaccine emergency use authorization (EUA) fact sheet. I am the parent or legal guardian of the child listed above and I give my permission for my child to receive the COVID-19 vaccine. I understand the benefits and risks of the COVID-19 vaccine. I understand that my child's immunization information will be sent to a database that will be used by other medical providers and school personnel.

_____	_____	_____
Printed name	**Signature**	**Date**

For office use only				
Dose ☐ 0.3 mL IM ☐ _____	**Site** ☐ RA ☐ LA	**Manufacturer**	**Lot #**	**Exp**

Date EUA info sheet given	**Date EUA published**	**Appointment?** ☐ Yes ☐ No	**Appointment date**

Vaccinator name (printed)	**Vaccinator signature**	**Date**

Prevaccination Checklist for COVID-19 Vaccination

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 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.

Name _____

Age _____

	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(s) did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	☐	☐	
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)*	☐	☐	☐
4. Have you received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	☐	☐	☐
5. 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	☐	☐	☐
6. 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.)*	☐	☐	☐

7. Check all that apply to you:

- ☐ Am a male between ages 12 and 39 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of Guillain-Barré Syndrome (GBS)

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists