COVID-19 Vaccine Consent

The COVID-19 Vaccine is administered by injection for the purpose of stimulating the production of antibodies needed for protection from the COVID-19 virus. Receiving the vaccine does not guarantee prevention of contracting the COVID-19 virus, as you may have been exposed prior to the development of adequate antibodies. This vaccine will not offer protection from becoming ill from another virus other than COVID-19. There is a possibility, as with other vaccines, that your body may not respond to the vaccine with antibody production.

I have had the opportunity to review my specific vaccine fact sheet for Recipients and Caregivers and have had my questions answered. I have been provided information on reporting side effects to the Vaccine Adverse Event Reporting System (VAERS). I acknowledge this information and consent to receiving the COVID-19 vaccine.

Please Check:
☐ Dose **1** ☐ Dose **2** ☐ Dose **3** ☐ Booster

	YES	NO
Pfizer Vaccine: I am 18 years of age or older.		
Pfizer Vaccine: I am 12 to 17 years of age and a parent or guardian is present.		
Moderna Vaccine: I am 18 years of age or older.		
Have you received a second dose of Pfizer or Moderna COVID vaccine 6 months or Johnson & Johnson 2 months prior to today? I request ☐ Pfizer or ☐ Moderna vaccine.		
Are you 65 years old or older?		
Are you 18 years old – 49 years old with an underlying medical condition?		
Are you 18 years old – 64 years old with an increased risk of exposure and transmission due to occupational or institutional setting?		
Do you have any allergies to any medication or a severe reaction to any vaccine or injectable therapy?		
Were you diagnosed with COVID-19 in the past 14 days?		
Have you ever had any serious reaction to a vaccine?		
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 within the past 90 days?		
Do you have a bleeding disorder or are you taking a blood thinner?		

Signature ____________ Print Name ____________ Patient Date of Birth ____________ Date ____________

Guarantor/Parent Signature ____________ Print Name ____________ County of Residence ____________

Nurse Signature ____________ Date ____________

Vaccination Provider Section

Pfizer

____ **Lot FF2590 Exp 3/31/22**

____ **Lot FH8028 Exp 2/28/22**

Moderna

____ **Lot 040C21A Exp: 12/30/21**

____ **Lot 032F21A Exp: 1/29/22**

Injection site: ☐ Right Deltoid ☐ Left Deltoid

Administration time ____________ Leave time ____________

Patient Status: Tolerated Well ☐ No reaction ☐ Vasovagal ☐

Complications: None ☐ Excessive pain ☐ Other ☐

Patient instructions given for reporting adverse reactions. Yes ☐ No ☐