COVID-19 Vaccine Informed Consent Form

Patient Name:_____ Date of Birth:_____

Address: _____ City/State:_____ ZIP:_____

Phone: _____ Insurance and ID #: _____

Ethnicity: □ Hispanic or Latino
□ Not Hispanic or Latino
□ Do not know
□ Prefer not to answer

Race: □ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Native Hawaiian or Other Pacific Islander
□ White
□ Do not know
□ Prefer not to answer

Primary Doctor: _____

Please check YES or NO for each statement below:

	Yes	No	Don't Know
1. In the past 3 weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?	□	□	□
2. In the past 3 weeks have you had contact with anyone who tested positive for COVID-19?	□	□	□
3. In the past 3 weeks have you had symptoms such as: fever, chills, cough, shortness of breath, difficulty breathing, fatigue, body aches, headache, loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	□	□	□
4. In the last 90 days, if you have tested positive for COVID-19, have you received treatment with convalescent plasma, remdesivir or monoclonal antibodies?	□	□	□
5. Have you had a reaction (serious or otherwise) to a vaccine in the past?	□	□	□
6. Do you currently feel ill and/or have a fever?	□	□	□
7. Do you have cancer, leukemia, AIDS or any other immune system problems?	□	□	□
8. Are you currently taking any steroid medications (such as prednisone), anticancer drugs or have you had radiation treatments?	□	□	□
9. Have you had a seizure or a brain or other nervous system problem?	□	□	□
10. For women, are you pregnant or is there a chance you could become pregnant during the next month?	□	□	□
11. Have you received any vaccinations in the past 2 weeks?	□	□	□

* Answering YES to any question may require us to check with your doctor before proceeding with the vaccination. *

By signing below:

- I attest to the accuracy of the above checklist and certify that I have read, or have had explained to me, the information on the CDC Approved Vaccine Information Sheet.
- I acknowledge having had an opportunity to ask questions which were answered to my satisfaction.
- I affirm that I understand the benefits and risks of the CDC approved vaccine and request the vaccine be given to me by an authorized pharmacist.

Patient Signature:_____ Date:_____

Parent/Guardian Signature (<18yrs) :_____ Date:_____

Pharmacy Use Only

Vaccine Administered: _____ Patient Temperature: _____

Vaccine Lot #: _____ Vaccine Expiration: _____ Site of Administration: _____

Administered By:_____ Date:_____