COVID-19 VACCINE CONSENT FORM

Section 1: INFORMATION ABOUT THE PATIENT

Last Name	First Name	Middle Initial	Sex

Date of Birth	Name of Legal Guardian	Relationship to Patient

Section 2: COVID-19 SCREENING QUESTIONS

Please check YES or NO for each question. Answers pertain to patient.	**Yes**	**No**
1. Is the patient sick today?		
2. Has the patient experienced any of the following symptoms in the last 10 days: fever, headache, chills, shortness of breath, loss of taste & smell, or a sore throat?		
3. Has the patient every had an allergic reaction to any vaccine or injectable therapy?		
4. Does the patient have an allergy to any medications, food, vaccine, or latex? List all allergies:		
5. Does the patient have a weakened immune system?		
6. Is the patient taking immunosuppressive drugs or therapies?		
7. Does the patient have a bleeding disorder or are they taking a blood thinner?		
8. Has the patient received passive antibody therapy as treatment for COVID-19?		

Section 3: VOLUNTARY CONSENT TO COVID-19 VACCINE

* I understand that COVID-19 can have serious life-threatening complications, and there is no way to know how COVID-19 will affect me, or the patient. I further understand that a COVID-19 vaccine may help keep me, or the patient, from becoming seriously ill, even if I do become infected with COVID-19.

* I have reviewed my specific vaccine EUA Fact Sheet or have had its contexts including the benefits, its usual and most frequent risks of receiving this vaccine, and alternatives explained to me, based up currently available information. I require two injections. I have had an opportunity to ask questions which have been answered to my satisfaction. I agree to remain at the vaccination location for at least 15 minutes after vaccine is administered in the event of adverse reaction.

I understand that:
* This vaccine is authorized for use under Emergency Use Authorization issued by the U.S. Food and Drug Administration (FDA). Under an EUA, the FDA may allow the use of unapproved medical products, or unapproved uses of approved medical products, in an emergency to diagnose, treat, or prevent serious life-threatening diseases or conditions when certain statutory criteria have been met, including that there are no adequate, approved, and available alternative.
* It is unclear how long any potential benefits of the vaccine may last. Additional research is needed to answer this question.

* Receiving this vaccine does not eliminate the need for masking, social distancing, and hand hygiene.

* I may still become ill with COVID-19 and may be able to transmit the virus to other individuals.
* This vaccine has not been studied on individuals who are pregnant or breastfeeding and it is recommended that I discuss vaccination with my provider prior to receiving the vaccine.
* I understand and acknowledge record of this vaccine administration to me will be reported to the sate and/or federal regulatory bodies in compliance with reporting for inventory management and use of National Stockpile vaccine supply.

I acknowledge this information and consent to receiving the COVID-19 vaccine.

Print Parent/Guardian name, if different from patient: _____

Patient/Guardian Signature: _____ **Date:** _____