COVID-19 Vaccine Consent Form

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IS THIS YOUR ☐ **FIRST** OR ☐ **SECOND** OR ☐ **THIRD** DOSE OF THE COVID VACCCINE? IF 2ND OR 3RD DOSE, WHAT WERE THE DATE(S) OF THE DOSES AND WHICH VACCINE DID YOU RECEIVE? ______________________________ & _____________________________

Section 1: Patient/Employee Information

NAME (Last)	(First)	**DATE OF BIRTH**	**GENDER**
ADDRESS			
CITY / **STATE**	**ZIP**	**DAYTIME PHONE NUMBER**	
PRIMARY CARE PHYSICIAN:	**Address**	**Phone Number**	
EMERGENCY CONTACT:	**Relation**	**Phone Number**	

Section 2: Screening Questions

	YES	NO
1. Do you have any drug allergies? Please list:		
2. Are you sick today? (For example, cold, fever, or acute illness)		
3. Do you have a bleeding disorder or are you on a blood thinner?		
4. Are you immunocompromised or are you on a medicine that affects your immune system?		
5. Are you pregnant or plan to become pregnant or breastfeeding?		
6. Have you received another COVID-19 vaccine elsewhere? If yes, name of vaccine_ __________		
7. Current Pharmacy? ____________		

Section 3: Consent

I have been given a copy and have read, or have had explained to me, the information in the **FACT SHEET** for the COVID-19 vaccine. I understand the FDA has authorized the emergency use of the COVID-19 vaccine, which is not an FDA-approved vaccine. I have had the chance to ask questions that were answered to my satisfaction.

If this is my first dose of the COVID-19 vaccine, I intend to receive a second dose in accordance with the time frame specified in the Fact Sheet to complete the vaccination series if applicable.

I understand the significant known and potential risks and benefits of the COVID-19 vaccine as explained in the FACT SHEET and that some potential risks and benefits may remain unknown, and **I REQUEST THE COVID-19 VACCINE BE GIVEN TO ME.**

I agree to stay in the vaccine administration area for fifteen (15) minutes (or longer if indicated by the vaccine administrator) after receiving my vaccination to ensure that no immediate adverse reactions occur, and I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician.

SIGNATURE OF PATIENT / EMPLOYEE / LEGAL REPRESENTATIVE: ______________________________

RELATIONSHIP TO PATIENT (if applicable) ____________________ **DATE:** ____________________

FOR ADMINISTRATIVE USE ONLY

Vaccine	Dose	Route	Date Dose Administered	Lot Number	Expiration Date	Name of Vaccine Administrator RPH./NTERN
MODERNA **1st or 2nd 3rd** **J &J** 1st 2nd **PFIZER** **1st or 2nd 3rd**	0.25ml 0.5 ml 0.3 ml	IM - L Arm IM - R Arm				