COVID Vaccine Informed Consent Form (all fields required)

First Name:_____ Last Name: _____M.I:_____Gender: M F

DOB:_____ Age:_____ Mother's Maiden Name: _____

Phone:_____ Email:_____

Street Address:_____City:_____State:_____ Zip code: _____

Hispanic/Latino?: Y N Race: White Asian Black Pacific Islander Native American Other

1. Are you feeling sick today? Y N
2. Have you ever received a dose of COVID-19 vaccine? Y N
   - If yes, which vaccine product did you receive?
     Pfizer Moderna Janssen (Johnson & Johnson) Another product _____
3. *Have you ever had an allergic reaction to:
   - A component of the COVID-19 vaccine, including:
     polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures Y N
     Polysorbate Y N
   - A previous dose of COVID-19 vaccine Y N
   - A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction. Y N
4. *Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? Y N
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies. Y N
6. Have you received any vaccine in the last 14 days? Y N
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? Y N
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? Y N
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? Y N
10. Do you have a bleeding disorder or are you taking a blood thinner? Y N
11. Are you pregnant or breastfeeding? Y N
12. Do you have dermal fillers? Y N

*For questions 3 and 4: allergic reaction 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.

Do you have health insurance? Y N Insurance Co. Name:_____
ID Number:_____ Subscriber's Name:_____ Subscriber's Birth Date: _____

Consent for Treatment and Privacy Notice

I certify that the information I have provided is true and accurate. I have had a chance to review the Covid-19 vaccine Information (EUA Fact Sheet) and consent to receive the vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine. I understand and agree that information related to my vaccine administration may be recorded in the Utah Statewide Immunization Information System (USIIS). We are required to inform you of our privacy practices for the information we collect and keep about you. I have been given a copy of the Notice of Privacy Practices and have had an opportunity to ask questions about how my information may be used.

Signature:_____ Date: _____
Relationship to Client: Self Parent Legal Guardian Other _____

Date	Manufacturer	Lot Number	Expiration	Dose	Route	Deltoid	Vaccinator
				0.5mL	IM	Right Left	