CONSIGLIO
WELLNESS CENTER

DISTRICT_____

COVID-19 VACCINE CONSENT FORM

Information about person to receive vaccine (please print)

Name: _____ **Birth date**: ___/___/_____ **Age**: _____ **Sex**: ☐ Male ☐ Female

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Phone: _____

The following questions will help determine if there is any reason you should not receive a COVID immunization injection.

Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.

Has the person to be vaccinated completed a COVID-19 vaccine series (Pfizer/Moderna/J&J) at least 2 months ago? ☐ No ☐Yes If yes, date:_____ Type/Brand of COVID vaccine:_____	
Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex?	☐ No ☐Yes
List all allergies: _____	
Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy?	☐ No ☐Yes
Is the person to be vaccinated sick today?	☐ No ☐Yes
Is the person to be vaccinated at least 18 years old?	☐ No ☐Yes
If no, is the person to be vaccinated at least 12 years old?	☐ No ☐Yes
Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner?	☐ No ☐Yes
Has the person to be vaccinated received any other vaccines in the past 14 days?	☐ No ☐Yes
Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19?	☐ No ☐ Yes

I have read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian).

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

Client/Parent/Guardian Signature: _____Date: _____

_____**FOR CLINIC USE ONLY**_____

Date vaccine administered: ____/____/_____ ***Date booster required***: ____/_____/_____

Vaccine manufacturer: _____ ***Lot number***: _____

Site of IM injection: *RDT or LDT or* _____ ***Dose***: *0.3ml 0.5ml*

Signature and title of vaccine administrator: _____

Comments: _____