COVID-19 Vaccination Consent Form

First Name	Last Name		Date of Birth	Male Female
Address			Phone Number	
City	State	Zip	Email	

Screening for Vaccination Eligibility

1. Do you currently or have you in the past 14 days, had a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	YES	NO
2. Have you tested positive for COVID-19 within the last 14 days?	YES	NO
3. Have you received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next 14 days?	YES	NO
4. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?	YES	NO
5. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause?	YES	NO
6. Are you currently pregnant or breastfeeding?	YES	NO
7. Are you under age 16?	YES	NO
8. Do you have a bleeding disorder or are you taking a blood thinner?	YES	NO
9. Have you tested positive for COVID-19 in the last 10 days?	YES	NO
10. Are you currently in quarantine for COVID-19 exposure?	YES	NO
11. If this is your second dose, when was the date of your first dose?		
12. If this is your second dose, which vaccine did you receive?		

Consent for Vaccination

- I will/have reviewed my answers to the questions above with the vaccinator.
- If I experience any adverse reactions after leaving, I will notify my primary care provider.
- I have viewed the Emergency Use Authorization Fact Sheet provided to me today.
- I understand the benefits and risks of the vaccine.
- The vaccine should be given to the above named person whom I am authorized to make this request.
- I understand that I can review a Notice of Privacy Practice at the time of vaccination.

Signature	Date