COVID-19 Vaccine Consent Form

Please read below carefully and ask for help if you need

The COVID-19 vaccine will reduce the risk of being suffering from the new type of Coronavirus disease as known as COVID-19.
Please be aware that the vaccine is not completely effective like all other medicines. It can take a few weeks for your body to build up protection from the vaccine. There is always a chance to get infected by Coronavirus even with the vaccine; however, the vaccine lessens the severity of any infection. Two doses will reduce the chance of being seriously ill and reduce the risk of death due to Coronavirus.
You still need to follow the health instructions in your workplace and in public areas, such as wearing a mask and keeping the distance from others after you received the COVID-19 vaccine.
The vaccine has some side effects as the other vaccines/medicines, but not everyone gets them.
The most likely side effects that you may experience from the vaccine

- Fever
- Pain at the injection site
- Redness and hardness of the skin at the injection site
- Headache
- Muscle aches or pain
- Joint aches or pain
- Fatigue (tiredness)
- Nausea/vomiting
- Chills
- Underarm gland swelling on the side of study vaccination

If you think you are experiencing any side effects, please remain calm and see your doctor immediately.
If you are currently pregnant or planning to get pregnant or your partner is planning to get pregnant; please see your doctor before getting vaccinated.

Medical History

Type a question

	Yes	No	Don't know
Do you have allergies to latex, food, medications, or vaccine components? (such as eggs, thimerosal, gelatin, neomycin, phenol, or bovine protein)?	○	○	○
Did you ever experience any serious reaction after getting a vaccine?	○	○	○
In the past year, did you receive a transfusion of blood or blood products, or get injected immune (gamma) globulin or any antiviral drug?	○	○	○
Did you have any brain or other nervous system problems?	○	○	○
Have you get vaccinated in the last 4 weeks?	○	○	○

Are your pregnant or planning to get pregnant or your partner is planning to get pregnant?

Do you have any of the followings? (select all that apply)

- [ ] Lung disease
- [ ] Heart disease
- [ ] Asthma
- [ ] Kidney Disease
- [ ] Diabetes
- [ ] Anemia
- [ ] Blood disorder
- [ ] None

Do you have immunocompromised condition? (select all that apply)

- [ ] Cancer
- [ ] Leukemia
- [ ] Lymphoma
- [ ] HIV/AIDS
- [ ] Transplant
- [ ] Asplenia
- [ ] CSF leak
- [ ] Cochlear implant
- [ ] None

Have you ever tested positive for COVID-19?

- ○ Yes
- ○ No

Test Date

Month Day Year

In the last 14 days, have you contacted with a person who was confirmed to have COVID-19?

- ○ Yes
- ○ No
- ○ Not sure

In the last 14 days, have you travelled internationally?

- ○ Yes
- ○ No

Do you have any of the followings?

- [ ] Coug

- [ ]
- [ ]
- [ ]
- [ ] Cold
- [ ] Fever
- [ ] Shortness of breath
- [ ] Sore throat
- [ ] Loss of smell/taste
- [ ] Abdominal pain/diarrhea

Personal Information

Name

First Name

Last Name

Email

example@example.com

Phone Number

Please enter a valid phone number.

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Emergency Contact Information

Name

First Name Last Name

Phone Number

Please enter a valid phone number.

Relation

By signing this form,
I hereby accept that I have read and understood the acknowledgment letter provided above.
I declare that the information I have provided above is correct.
I am giving my full consent to get the COVID-19 vaccine of my own will.

Date

Month Day Year