7.	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	□ Yes	□ No	□ Unknown
8.	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	□ Yes	□ No	□ Unknown
9.	Do you have a bleeding disorder or are you taking a blood thinner?	□ Yes	□ No	□ Unknown
10.	Have you received a previous dose of the COVID-19 vaccine? If yes, which vaccine? □ Moderna □ Pfizer		□ No	Date: _____ (if applicable)

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not undergone the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available is based on the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent

I have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if my vaccine requires two doses, I will need to be administered (given) two doses of this vaccine in order for it to be effective. I have had a chance to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health plan, Medicare or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

Recipient/Surrogate/Guardian (Signature) recipient	Date / Time	Print Name	Relationship to Patient (if other than recipient)

Telephonic Interpreter's ID # **OR**	Date / Time	

Signature: Interpreter	Date/ Time	Print: Interpreter's Name and Relationship to Patient

Area Below to be Completed by Vaccinator

Which vaccine is the patient receiving today?

Vaccine Name	Administration		EUA Fact Sheet Date	Manufacturer & Lot Number
Pfizer/ BioNTech	First Dose	Second Dose		
Moderna	First Dose	Second Dose		
Astra-Zeneca	First Dose	Second Dose		
Janssen	Single Dose			

Administration Site	Left Deltoid	Right Deltoid	Left Thigh	Right Thigh
Dosage	0.5 ml	0.3 ml		

I have provided the patient (and/or parent, guardian or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

Vaccinator Signature: _____

Use of this form is optional. In the ongoing effort to address health disparities it is essential that all demographic information is collected at the time of COVID-19 vaccination including sex/gender identity and race/ethnicity.* **Updated January 20, 2021