COVID-19 Vaccination Consent Form

Last Name *(Please print)*	First Name, M.I.	Date of Birth	☐ Male ☐ Female	
Address		City	State	Zip
Phone Number	Race/Ethnicity ☐ Asian ☐ Black ☐ Hispanic/Latino ☐ White ☐ Native American ☐ Pacific Islander ☐ Other		Health Insurance Information	

SCREENING FOR VACCINATION ELIGIBILITY & PRIOR IMMUNIZATION

1. Is the child currently pregnant?	Yes	No
2. Is the child currently breastfeeding?	Yes	No
3. Has the child 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
4. Have the child had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of a COVID-19 vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?	Yes	No
5. Have the child received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next 14 days?	Yes	No
6. Have the child received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?	Yes	No
7. Is the child receiving chemotherapy or radiation?	Yes	No
8. Is the child currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?	Yes	No
9. Do the child have a bleeding disorder or are you taking an aspirin therapy?	Yes	No
10. Has the child tested positive for COVID-19 in the last 10 days?	Yes	No
11. Is the child currently in quarantine for COVID-19 exposure?	Yes	No
12. . Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, or a spinal fluid leak?	*Yes* *No*	
13. . Does the child live with any family members with an immune system problem?		

INFORMED CONSENT FOR VACCINATION

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving the observation area, I will notify the facility and my primary care provider. I have viewed the Emergency Use Authorization Fact Sheet provided to me today. I have received education and understand the benefits and potential side effects associated with the vaccine. I have had the opportunity to ask and have my questions answered, and consent to receive the COVID-19 vaccine.

Signature of Parent/Guardian _____ Date_____

Print Name of Responsible Party Providing Consent (if applicable)_____

Signature of Vaccinator _____ Date_____

Vaccine	Date Vaccination and EUA Given	Route IM R L	Manufacturer	Lot No.	Printed Name and Signature of Vaccine Administrator