# COVID Vaccine Consent Form

___________________________________________________________________________

*Last Name* *First Name* *Date of Birth* *Gender*

___________________________________________________________________________

*Address* *City* *State* *Zip*

___________________________________________________________________________

*Race* *Ethnicity* *SS Number* *State* *Driver's License/ID #*

This information may be used to have your vaccine administration fee paid for by the United States Health Resource & Services Administration's COVID-19 Program for Uninsured Patients,

I wish to receive the COVID-19 vaccine. I have been given access to the **EMERGENCY USE AUTHORIZATION FACT SHEET FOR RECIPIENTS AND CAREGIVERS** informing me of possible side effects associated with the vaccine and understand the benefits and risks of the vaccination. I have had the opportunity to ask questions related to the risks. Further, as a condition of receiving the vaccination, I agree to release from liability and hold harmless St. Mary's, Covenant Health, Inc., their respective officers, directors and staff, and the administrator of the vaccine, against any claim, injury, or damages associated with my receipt of the vaccine.

**Screening Questions: [NOTE: If Yes to any of questions 1 – 4, or No to 7a., DO NOT ADMINISTER VACCINE. If yes to questions 5 or 6, monitor for 30 minutes post injection]**

| | Yes | No |
|---|---|---|
| 1. Are you feeling sick today? (for example: a fever, respiratory symptoms, or other acute | | |
| 2. Have you had an allergic reaction to a COVID vaccine or any component of a COVID | | |
| 3. Have you received any other vaccine within the past 14 days? | | |
| 4. Have you received monoclonal antibody therapy for treatment of COVID-19 within the | | |
| 5. Have you ever had an immediate allergic reaction of any severity (defined as an allergic reaction within 4 hours) after receiving another vaccine or injectable medication therapy (including intramuscular, intravenous, or subcutaneous injections)? | | |
| 6. Have you ever had a severe allergic reaction (e.g. anaphylaxis) due to any cause (including other medications, foods, substances, bee stings, or environmental exposures, | | |
| 7. **For women**: Are you pregnant or considering becoming pregnant within the next two months? | | |
| a. **If yes**: I have spoken with my provider about receiving the COVID-19 vaccine. | | |

Based on the above, I have been informed that following receiving the vaccine:

- ☐ I should be observed for a period of 30 minutes. This is based on the CDC recommendation due to having a history of an immediate allergic reaction of any severity to a vaccine or injectable therapy or a history of anaphylaxis due to any cause.
- ☐ I should be observed for a period of 15 minutes based on the CDC recommendation that all other persons should be observed for this time frame.

___________________________________________________________________________

**Patient Signature (or parent, guardian, or authorized representative)** **Date**

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| FOR OFFICE USE ONLY | | |
|---|---|---|
| **First Dose X** | **Second Dose ◯** | |
| **Site: R Deltoid IM** | **L Deltoid IM** | |
| **Date vaccinated:** | | |
| **Manufacturer: Moderna COVID-19 Vaccine** | | |
| **Lot #** | **NDC #** | **Exp. Date:** |
| **Administrator Name (Printed) / Signature** | | |