## **COVID-19 Vaccine Consent Form**



## **Patient Information (Vaccine Recipient):**

Name (First)  Name (Middle):  Mother's Maiden Name:  Address  Preferred Arm: Left Right  City  State Zip  Phone Number  Primary Care Provider Name:  Emergency Contact Name:  Emergency Contact Name:  Relation:  Phone Number:  Patient Screening Questions: ANSWER THE DAY OF VACCINATION  Question  Question  Phase Qualification  VES  NO  Don't Know  1. Are you feeling sick today?  2. Have you ever received a dose of COVID-19 Vaccine before:  O Vaccine manufacturer (example: Pfizer, Moderna, Janssen):  Date of first dose:  3. Have you ever had an allergic reaction to:  (this would include a several single reaction to:  would also include an ellergic reaction that coursed which, swelling, or report of the course of the properties of the properties of a large from the course of the properties of a large from the course of the properties of the properties of the properties of a large from the course of the properties of the p						_						
Address  City  State  Zip  Phone Number  Primary Care Provider Name:  Emergency Contact Name:  Relation:  Phone Number:  Question  Question  1. Are you feeling sick today?  2. Have you ever received a dose of COVID-19 Vaccine?  • If you have received a dose of COVID-19 Vaccine before:  • Vaccine manufacturer (example: Pfizer, Moderna, Janssen):  • Date of first dose:  3. Have you ever had an allergic reaction to:  (This would also include a severe allergic reaction to:  an allergic for the state of the	Name (Last)			Date of Birth	Gender	Race	Ethnicity					
City State Zip Phone Number  Primary Care Provider Name:  Emergency Contact Name: Relation: Phone Number:  Patient Screening Questions: ANSWER THE DAY OF VACCINATION  Question Phase Qualification  1. Are you feeling sick today?  2. Have you ever received a dose of COVID-19 Vaccine?  • If you have received a dose of COVID-19 Vaccine before:  • Vaccine manufacturer (example: Pfizer, Moderna, Janssen):  • Date of first dose:  (This would include a severe allergic reaction to: (This would include a severe allergic reaction to: (This would include a severe allergic reaction to: (This would include a severe allergic reaction in the properties of the covered within a chours that caused heve, swelling, or assyriatory districts, including wheeting)  • A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures  • Polysorbate  • A previous dose of COVID-19 Vaccine  4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?  This would include a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine in the last 14 days?  5. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? Index: monoclonal antibodies or convalescent serum) as treatment for COVID-19 Index: monoclonal antibodies does not include antibodies or convalescent serum) as treatment for COVID-19 Index: monoclonal antibodies does not include antibodies that would be prescribed to you and filled at a pharmacy!  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?	Name (First)			Name (Middle):	Mother's M	aiden Name:						
Primary Care Provider Name:  Emergency Contact Name:  Relation:  Phone Number:  Patient Screening Questions: ANSWER THE DAY OF VACCINATION  Question  Question  Phase Qualification  YES NO Don' Know  1. Are you feeling sick today?  2. Have you ever received a dose of COVID-19 Vaccine?  • If you have received a dose of COVID-19 Vaccine before:  • Vaccine manufacturer (example: Pfizer, Moderna, Janssen):  • Date of first dose:  3. Have you ever had an allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen* or that caused you to go to the hospital. It would also include a savere allergic reaction [e.g., including byterhylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures  • Polysorbate  • A previous dose of COVID-19 Vaccine  4. Have you ever had an allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen* or that caused you to go to the hospital. It would also include an allergic reaction to another vaccine (often than COVID-19 Vaccine) or an injectable medication?  (This would include severe allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?  (This would include as evere allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen* or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hive, swelling, or respiratory distress, including wheering.)  5. Have you ever had a severe allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?  This would include food, pet, environmental, or oral medication allergies.  6. Have you received any vaccine in the last 14 days?  7. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? Inote: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy.]  9. Do you hav	Address				Preferred Arm:		m: L	.eft	eft Right			
Primary Care Provider Name:  Emergency Contact Name:  Relation:  Phone Number:  Patient Screening Questions: ANSWER THE DAY OF VACCINATION  Question  Question  Phase Qualification  YES NO Don' Know  1. Are you feeling sick today?  2. Have you ever received a dose of COVID-19 Vaccine?  • If you have received a dose of COVID-19 Vaccine before:  • Vaccine manufacturer (example: Pfizer, Moderna, Janssen):  • Date of first dose:  3. Have you ever had an allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen* or that caused you to go to the hospital. It would also include a savere allergic reaction [e.g., including byterhylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures  • Polysorbate  • A previous dose of COVID-19 Vaccine  4. Have you ever had an allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen* or that caused you to go to the hospital. It would also include an allergic reaction to another vaccine (often than COVID-19 Vaccine) or an injectable medication?  (This would include severe allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?  (This would include as evere allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen* or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hive, swelling, or respiratory distress, including wheering.)  5. Have you ever had a severe allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?  This would include food, pet, environmental, or oral medication allergies.  6. Have you received any vaccine in the last 14 days?  7. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? Inote: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy.]  9. Do you hav	City			Zin	Phone Num	her						
Emergency Contact Name: Relation: Phone Number:  Patient Screening Questions: ANSWER THE DAY OF VACCINATION  Question  Question  1. Are you feeling sick today?  2. Have you ever received a dose of COVID-19 Vaccine Pfizer, Moderna, Janssen):  Date of first dose:  Date of first dose:  This would include a severe allergic reaction to:  (This would include a severe allergic reaction to:  (This would have a severe allergic reaction for:  A component of the COVID-19 Vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures  Polysorbate  A previous dose of COVID-19 Vaccine  4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?  (This would include a severe allergic reaction for, anaphylaxis) that required treatment with epinephrine or EpiPen* or that caused lives, swelling, or repiratory distress, including wheeling.)  The would include severe allergic reaction for an allergic reaction for that coursed within 4 hours that caused lives, swelling, or repiratory distress, including wheeling.)  The would include so severe allergic reaction for an any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  6. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? Inote: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy!  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?		•	State	2.10	Thorne real							
Patient Screening Questions: ANSWER THE DAY OF VACCINATION  Question  Question  Question  VES  NO  Don't Know  1. Are you feeling sick today?  2. Have you ever received a dose of COVID-19 Vaccine?  • If you have received a dose of COVID-19 Vaccine before:  • Vaccine manufacturer (example: Pfizer, Moderna, Janssen):  • Date of first dose:  3. Have you ever had an allergic reaction to:  (This would include as severa allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen* or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheering.)  • A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures  • Polysorbate  • A previous dose of COVID-19 Vaccine  4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?  (This would include as veere allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen* or that caused you to go to the hospital. It would also include an allergic vaccion that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheeling.)  5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  6. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? Inote: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy)  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a beleeding disorder or are you taking	Priı	Primary Care Provider Name:										
Question  Question  Question  Question  Are you feeling sick today?  Have you ever received a dose of COVID-19 Vaccine?  If you have received a dose of COVID-19 Vaccine before:  Vaccine manufacturer (example: Pfizer, Moderna, Janssen):  Date of first dose:  Have you ever had an allergic reaction to:  (This would include a severe allergic reaction in the course within a hours that caused hives, swelling, or respiratory distress, including wheezing.)  A component of the COVID-19 vaccine, including polyethylere glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures  Polysorbate  A previous dose of COVID-19 Vaccine  Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?  (This would include a severe allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?  (This would include a severe allergic reaction fee, anaphylaxis) that required treatment with epinephrine or EpiPen* or that caused you up so to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or anny vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  Have you received any vaccine in the last 14 days?  Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled or a pharmacy]  Do you have a weekened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	Emergency Contact Name: Relation: Phone Number:						lumber:					
Question  Question  Question  Question  Are you feeling sick today?  Have you ever received a dose of COVID-19 Vaccine?  If you have received a dose of COVID-19 Vaccine before:  Vaccine manufacturer (example: Pfizer, Moderna, Janssen):  Date of first dose:  Have you ever had an allergic reaction to:  (This would include a severe allergic reaction in the course within a hours that caused hives, swelling, or respiratory distress, including wheezing.)  A component of the COVID-19 vaccine, including polyethylere glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures  Polysorbate  A previous dose of COVID-19 Vaccine  Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?  (This would include a severe allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?  (This would include a severe allergic reaction fee, anaphylaxis) that required treatment with epinephrine or EpiPen* or that caused you up so to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or anny vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  Have you received any vaccine in the last 14 days?  Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled or a pharmacy]  Do you have a weekened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	Phase Overliff and incr											
Question  1. Are you feeling sick today?  2. Have you ever received a dose of COVID-19 Vaccine?  • If you have received a dose of COVID-19 Vaccine before:  • Vaccine manufacturer (example: Pfizer, Moderna, Janssen):  • Date of first dose:  3. Have you ever had an allergic reaction to:  (This would include a severe allergic reaction teg., anaphylaxis) that required treatment with epinephrine or EpiPen* or that caused you to go to the hospital. It would also include an allergic reaction that occurred within a hours that caused hives, swelling, or respiratory distress, including wheezing.)  • A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures  • Polysorbate  • A previous dose of COVID-19 Vaccine  4. Have you ever had an allergic reaction teg., anaphylaxis) that required treatment with epinephrine or EpiPen* or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or or all medication allergies.  6. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?  8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 flote: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a phormacy!  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?	Pati	Patient Screening Questions: ANSWER THE DAY OF VACCINATION										
2. Have you ever received a dose of COVID-19 Vaccine?  • If you have received a dose of COVID-19 Vaccine before:  • Vaccine manufacturer (example: Pfizer, Moderna, Janssen):  • Date of first dose:  • A component of the COVID-19 vaccine, anaphylaxis; that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  • A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures  • Polysorbate  • A previous dose of COVID-19 Vaccine  4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?  (This would include a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  6. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?  8. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you t	Question							YES	NO	Don't Know		
If you have received a dose of COVID-19 Vaccine before:  O Vaccine manufacturer (example: Pfizer, Moderna, Janssen):  Date of first dose:  (This would include a severe allergic reaction to: (This would include a severe allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  A component of the COVID-19 Vaccine, including polyetyleylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures  Polysorbate  A previous dose of COVID-19 Vaccine  Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen* or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  This would include a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?  Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?  Have you and filled at a pharmacy!  Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  Do you have a bleeding disorder or are you taking a blood thinner?	1.	1. Are you feeling sick today?										
O Vaccine manufacturer (example: Pfizer, Moderna, Janssen): O Date of first dose:  3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  • A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures  • Polysorbate  • A previous dose of COVID-19 Vaccine  4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  6. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? [note: monoclonal antibodies or convalescent serum) as treatment for COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?	2.	. Have you ever received a dose of COVID-19 Vaccine?										
O Vaccine manufacturer (example: Pfizer, Moderna, Janssen): O Date of first dose:  3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  • A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures  • Polysorbate  • A previous dose of COVID-19 Vaccine  4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  6. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?  8. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?		If you have received a dose of COVID-19 Vaccine before:										
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  • A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures  • Polysorbate  • A previous dose of COVID-19 Vaccine  4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  6. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?		,										
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  • A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures  • Polysorbate  • A previous dose of COVID-19 Vaccine  4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  6. Have you received any vaccine in the last 14 days?  7. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?												
(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen* or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  • A component of the COVID-19 vaccine, including polyethylene glycol [PEG], which is found in some medications, such as laxatives and preparations for colonoscopy procedures  • Polysorbate  • A previous dose of COVID-19 Vaccine  4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?  (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen* or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  6. Have you received any vaccine in the last 14 days?  7. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?	2											
A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures  Polysorbate  A previous dose of COVID-19 Vaccine  Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  Have you received any vaccine in the last 14 days?  Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19? [note: monoclonal antibodies or convalescent serum) as treatment for COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]  Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  Do you have a bleeding disorder or are you taking a blood thinner?	<b>J</b> .	(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It										
medications, such as laxatives and preparations for colonoscopy procedures  • Polysorbate  • A previous dose of COVID-19 Vaccine  4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?  (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  6. Have you received any vaccine in the last 14 days?  7. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?  8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?												
A previous dose of COVID-19 Vaccine  Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  Have you received any vaccine in the last 14 days?  Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?  Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]  Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  Do you have a bleeding disorder or are you taking a blood thinner?												
<ul> <li>4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen* or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)</li> <li>5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.</li> <li>6. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?</li> <li>8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]</li> <li>9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?</li> <li>10. Do you have a bleeding disorder or are you taking a blood thinner?</li> </ul>		Polysorbate										
injectable medication?  (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  6. Have you received any vaccine in the last 14 days?  7. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?  8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy.]  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?		A previous dose of COVID-19 Vaccine										
(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  6. Have you received any vaccine in the last 14 days?  7. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?  8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?	4.	•	ic reacti	on to another vaccine (	other than CO	VID-19 vaccii	ne) or an					
you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)  5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  6. Have you received any vaccine in the last 14 days?  7. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?  8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?		·										
<ul> <li>5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.</li> <li>6. Have you received any vaccine in the last 14 days?</li> <li>7. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?</li> <li>8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]</li> <li>9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?</li> <li>10. Do you have a bleeding disorder or are you taking a blood thinner?</li> </ul>		you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or										
component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.  6. Have you received any vaccine in the last 14 days?  7. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?  8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?	5											
<ul> <li>6. Have you received any vaccine in the last 14 days?</li> <li>7. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?</li> <li>8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]</li> <li>9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?</li> <li>10. Do you have a bleeding disorder or are you taking a blood thinner?</li> </ul>	٥.											
<ul> <li>7. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that you had COVID-19?</li> <li>8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]</li> <li>9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?</li> <li>10. Do you have a bleeding disorder or are you taking a blood thinner?</li> </ul>												
you had COVID-19?  8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?	6.	Have you received any vacc	ine in th	e last 14 days?								
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?	7. Have you ever had a positive test for COVID-19 or has a health care provider ever told you that											
treatment for COVID-19? [note: monoclonal antibodies does not include antibiotics that would be prescribed to you and filled at a pharmacy]  9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?												
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?	8.											
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?												
or do you take immunosuppressive drugs or therapies?  10. Do you have a bleeding disorder or are you taking a blood thinner?	9.											
10. Do you have a bleeding disorder or are you taking a blood thinner?		· · · · · · · · · · · · · · · · · · ·										
11. Are you pregnant or breastfeeding?	10.				thinner?							
	11.	. Are you pregnant or breast	feeding?									

## Consent (check each box below after reading and signing): I understand the benefits and risks of the COVID-19 vaccine as described in the Emergency Use Authorization (EUA) Fact Sheet, a copy of which I was provided with this Consent Form. I have had a chance to ask questions that were answered to my satisfaction. I request the vaccine to be given to me or to the person named above, a minor for whom I represent that I am authorized to sign this Consent Form. I agree to stay in the vaccine administration area for fifteen (15) minutes or longer if indicated by the vaccine administrator after receiving my vaccine to ensure that no immediate adverse reactions occur. I understand that at this time, certain COVID-19 vaccines require 2 doses given 21-28 days apart depending on the manufacturer. If this is my fist dose of the COVID-19 vaccine, I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the vaccination series. I understand that I will be receiving the vaccination at no cost to me. If insured, please bring in your prescription and medical insurance cards for your vaccine appointment. I authorize the pharmacy to bill my insurance on my behalf for the immunization – understanding I will not incur any costs. If uninsured, you must check the box below to attest that the following information is true and accurate: ☐ I do not have any insurance, including but not limited to, Medicare, Medicaid, or any other private or governmentfunded benefit plan. For uninsured patients, please select at least one of the following that you will bring with you to your appointment. This is needed in order to have your vaccine administration fee paid for by the United States Health Resources & Services Administration's COVID-19 Program. ☐ Social Security Number ☐ State identification number and state of issuance \_\_\_\_\_ ☐ Driver's license number and state of issuance Signature of Person to Receive Vaccine & EUA /VIS (or Signature of Parent/Guardian if Patient is < 18 years old): Signature: \*\*PHARMACY USE ONLY\*\* Vaccine Vaccine Lot Dose Route **Date Dose Expiration Date** Name of **Administered** Manufacturer Number Vaccine Administrator ☐ 1<sup>st</sup> Dose ☐ IM - L Arm COVID-☐ 2<sup>nd</sup> Dose ☐ IM - R Arm 19 ☐ 1<sup>st</sup> Dose ☐ IM - L Arm COVID-☐ 2<sup>nd</sup> Dose ☐ IM - R Arm 19 Pharmacist Name who reviewed this form: Pharmacist Signature: If certified vaccinator is different than the pharmacist who reviewed the form: Name: \_\_\_ Signature: \_\_\_\_\_