COVID-19 Vaccination Consent under Emergency Use Authorization

PATIENT INFORMATION

Last Name:	**First Name:**	**Middle Initial:**

Date of Birth: ____/____/____________

HEALTHHISTORY

		YES	NO	UNKNOWN
1.	Are you feeling sick today?	☐	☐	☐
2.	Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? ☐Pfizer ☐Moderna ☐ Johnson & Johnson Date:____________________	☐	☐	☐
3.	Have you ever had a severe 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 a severe allergic reaction after any vaccination or injectable medication?	☐	☐	☐
5.	Have you ever had a severe allergic (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 either tested positive for COVID-19 in the last 10 days or are you currently under an order of isolation by a doctor or health department related to recent COVID-19 infection?	☐	☐	☐
7.	Have you received any vaccine in the last 14 days?	☐	☐	☐
8.	Are you breastfeeding or pregnant?	☐	☐	☐
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?	☐	☐	☐

Updated: 04/19/2021

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HEALTH HISTORY (continued)

		YES	NO	UNKNOWN
10.	Have you received passive antibody therapy (monoclonal antibodies or convalescent plasma) as treatment for COVID-19?	☐	☐	☐
11.	Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
12.	Do you have dermal fillers?	☐	☐	☐
13.	Do you have a history of fainting with vaccinations or blood draws?	☐	☐	☐

CONSENT TO VACCINATE

I have been provided and have read, or had explained to me the vaccine information sheet about the COVID-19 vaccination. I understand that for Pfizer and Moderna vaccine, two doses will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (or ensured the person named above for whom I am authorized to provide consent was given a chance to ask questions). I understand the benefits and risks of the vaccination as described. I understand there may be risks to the vaccine that are not known at this time. 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 consent). I understand that it is recommended that I remain on site for at least 15 minutes after receiving the vaccine and that, depending on the recommendations of medical professionals, I may be asked to remain on site longer for monitoring.

PREP ACT NOTICE

The federal Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP (Countermeasures Injury Compensation Program) to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The COVID-19 vaccine is a covered countermeasure. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV–2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the CICP and filing a claim is available by calling 1-855-266-2427 or visiting https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that I have received or have been advised of the St. Louis County Department of Public Health’s Notice of Privacy Practices and where I can obtain any revisions made to this Notice.

PRINTED NAME:

SIGNATURE OF PATIENT/GUARDIAN/LEGAL REPRESENTATIVE	RELATIONSHIP TO CLIENT (if applicable)	TODAY'S DATE
		/ /

CLINICAL STAFF ONLY

Injection Site	Manufacturer	Dose #	Lot #:	Administered by/ date
☐ Left Arm ☐ Right Arm ☐ Other:	☐ Pfizer ☐ Moderna ☐ Johnson & Johnson	☐ 1 ☐ 2	Expiration date:	