



COVID-19 VACCINE CONSENT FORM 2020-2021

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Age:** _____ **Gender:** Female Male **Phone:** _____

Facility:

HHK RTH KHC EMS TCH Dialysis East Dialysis West RTC Other: _____

Screening Questions	Yes	No	Don't Know
I am 18 years old or older.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a flu shot or any other vaccine in the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with COVID-19 or under quarantine for COVID exposure in the past 14 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you received antibody or plasma treatment for COVID in past 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel sick today? Do you have a fever? Have you taken any fever reducing medications in past 48 hours for fever?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have allergies to latex, medications, food or vaccines (e.g., eggs, bovine protein, gelatin, gentamycin, neomycin, phenol, yeast or polyethylene glycol)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a severe allergic reaction called anaphylaxis (e.g., trouble breathing, broke out in hives, had facial or tongue swelling, had low blood pressure) to any food, medication, vaccine, insect stings, preservatives, cosmetics or any other injections? Do you carry an epipen? Have you been hospitalized for severe allergic reactions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you immunocompromised or on medications that affect your immune system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant, planning to become pregnant in the next 3 months or breast feeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For those who have already received a COVID-19 vaccine. Manufacturer: _____ Date administered: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please read and check all boxes below:

- FDA has authorized the emergency use of the COVID-19 Vaccine, which is not an FDA-approved vaccine.
- The recipient or their caregiver has the option to accept or refuse COVID-19 Vaccine.
- Information about vaccine recipient will be shared with IHS and de-identified recipient information will be sent to CDC within 24 hours.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving the COVID-19 vaccine(s). I believe the benefits outweigh the risks and have received, read and/or had explained to me the EUA Fact Sheet on the vaccine(s). I assume full responsibility for any reactions that may result.
- I authorize the release of the above medical information to the healthcare worker administering the vaccine.
- I consent and request that the COVID-19 vaccine I receive today be entered into my patient chart at GRHC.

Patient/Authorized Person signature: _____ **Date:** _____