Temp_____ Height_____ Weight_____ Time Given:_____

Hamilton Memorial HOSPITAL DISTRICT

COVID-19 VACCINE CONSENT

SECTION A: (Please print clearly)

First Name: _____ Last Name: _____ Date of Birth: _____

Address_____City_____State_____Zip_____

Phone:_____ Allergies:_____

Race: White African American Asian American Indian Alaska Native

Native Hawaiian or Pacific Islander Unknown Multiracial **Ethnicity**: Hispanic Not Hispanic Unknown

SECTION B: (Patient to complete this Section)	**1st Vaccine**			**2nd Vaccine**		
COVID-19 Screening Questions	**Yes**	**No**	**Do not know**	**Yes**	**No**	**Do not know**
1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?						
2. In the past two weeks, that you know of, have you had contact with anyone who has tested positive for COVID-19?						
3. Do you currently or have you in the past 14 days, had a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?						
Immunization Screening Questions	**Yes**	**No**	**Do not know**	**Yes**	**No**	**Do not know**
1. Are you sick today? (For example: a cold, fever or acute illness)						
2. Do you have allergies or reactions to any foods, medication, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, PEG-polyethylene glycol)						
3. Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?						
4. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?						
5. Have you recently received Monoclonal Antibodies for the treatment of COVID-19?						
6. Do you take anticoagulation medication? For example: warfarin, Coumadin or other blood thinner?						
7. Do you have long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?						
8. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease or any other immune system problem?						
9. Do you have a weakened immune system or in past 3 months, taken medications that weaken it such as cortisone, prednisone, other steroids, anticancer drugs, or radiation treatments?						
10. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?						
11. For women, are you pregnant or breastfeeding or is there a chance you could become pregnant during the next month?						
12. Have you received any vaccination or TB skin test in the past 4 weeks?						

SECTION C:

Consent for Services

- I understand this COVID-19 vaccine is not FDA-approved, but has been authorized for administration by the FDA under an Emergency Use Authorization. I have been given a copy of the Fact Sheet for Recipients and Caregivers (also available at www.cvdvaccine.com) and have read the Fact Sheet prior to administration of my vaccine.
- I have read the information provided about the vaccine that I am to receive. I have had the chance to ask questions that were answered to my satisfaction.
- I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result.
- I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.
- I understand this is: a two-dose vaccine, and I agree to receive the second vaccine in -- 24-28 days for Moderna and 21 days for Pfizer-- after the initial dose **OR** the Janssen Johnson & Johnson Vaccine is a single dose.
- I understand that I should not receive any other vaccine or TB test within 14 days of each dose.
- I consent to allow the access to my medical records for the purposes of documenting the vaccine, administering the vaccine, tracking of the second dose of vaccine, and reporting to Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE).
- I agree to have a copy of this (COVID-19 Vaccine Consent) sent to my primary care provider using the contact information provided below:

Doctor/primary care provider name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip code: _____

I want to receive the following vaccination(s): _____

Signature of Recipient: _____ Date: _____

If someone else manages health decisions on your behalf, please provide the following:

_____	_____	_____
Caregiver or Financially Responsible Party Name	Relationship	Phone Number

Vaccine Administration Information for Immunizer:

VACCINE #1

Administration Date	Vaccine	Manufacturer	EUA Fact Sheet Date
		IM Deltoid ☐ L ☐ R	
Lot #	Exp. Date	Route	Site	Volume (mL)

Signature of Nurse providing immunization: _____ Date: _____

VACCINE #2

Administration Date	Vaccine	Manufacturer	EUA Fact Sheet Date
		IM Deltoid ☐ L ☐ R	
Lot #	Exp. Date	Route	Site	Volume (mL)

Signature of Nurse providing immunization: _____ Date: _____