COVID-19 VACCINE CONSENT

Patient Name:_____ D.O.B: _____

1. Is the patient feeling sick today? YES NO
2. Is the patient in quarantine or isolation for COVID-19? YES NO
3. Has the patient ever received a dose of a COVID-19 Vaccine? YES NO
   - If so which one?_____
   - If so date of first dose:_____
4. Has the patient ever had a SEVERE allergic reaction(ANAPHYLAXIS) to anything? YES NO
   - Has the patient been prescribed an EpiPen? YES NO
5. Has the patient ever had an allergic reaction after receiving a COVID-19 vaccine or another vaccine or injectable medicine? YES NO
6. Has the patient ever had a severe allergic reaction to any component of a COVID-19 Vaccine, including polysorbate or polyethylene glycol, which is found in some Medications, such as laxatives and preparations for colonoscopy procedures? YES NO
7. Does the patient have a history of:
   - Myocarditis or Pericarditis? YES NO
   - Multisystem Inflammatory Syndrome (MIS-C) after a COVID-19 infection? YES NO
   - Weakened immune system (ie: HIV, cancer) or taking immunosuppressive Medications? YES NO
   - Bleeding disorder or taking blood thinners? YES NO
   - Guillain-Barre Syndrome? YES NO

****REQUIRED FOR REPORTING TO THE HEALTH DEPARTMENT (PLEASE PROVIDE PATIENTS INFORMATION)****

GENDER: M F

RACE: American Indian/Alaska Native Asian Black/African American

Native Hawaiin/Pacific Islander White Other

ETHNICITY: Hispanic/Latino Non Hispanic/Latino Unknown Decline

Guardian Signature:_____ Date:_____

OFFICE USE ONLY:

INJECTION SITE: LEFT RIGHT