COVID-19 VACCINATION CONSENT FORM

ARROYO VISTA
FAMILY MEDICINE

PATIENT INFORMATION

Last Name (Print):	First Name:	M.I.	Date of Birth:	Age:

Street Address:	City:	State:	Zip:

Primary Phone Number (☐ Cell ☐ Home):	Gender: ☒ Male ☐ Female	Mother's First Name:

Which category best describes your race? ☐ American Indian or Alaska Native ☐ Black or African American ☐ White
☐ Hawaiian or other Pacific Islander ☐ Asian (includes Pakistan or Indian origins) ☐ Other:_____
Do you consider yourself Hispanic/Latino? ☐ Yes ☐ No ☐ **I do not wish to disclose race or ethnicity**

SCREENING FOR VACCINE ELIGIBILITY

You should not get vaccinated if you:

- are under 18 years of age.
- had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to 1) any vaccine or injectable therapy; 2) any component of a COVID-19 Vaccine, including lipid nanoparticles or polyethylene glycol (PEG); or 3) a history of anaphylaxis due to any cause.
- received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next 14 days.
- received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days.

Please let the doctor know if:

- are currently sick. For example, if you are experiencing fever, chills cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.
- are currently in quarantine for COVID-19 or have tested positive for COVID-19 in the past 90 days.

Do you have any health conditions or immunocompromised conditions that may give you priority in receiving the vaccine and/or may impact the decision whether or not you should receive the vaccine? (Check all that apply.)

☐ Anemia	☐ Asthma	☐ Blood Disorder	☐ Cancer	☐ Diabetes
☐ Down Syndrome	☐ Heart Disease	☐ HIV/AIDS	☐ Hypertension	☐ Kidney Disease
☐ Leukemia	☐ Liver disease	☐ Lung Disease	☐ Lymphoma	☐ Neurological Disorder
☐ Obesity	☐ Pregnancy/Breastfeeding	☐ Sickle Cell Disease	☐ Smoker	☐ Stroke
☐ Transplant	☐ None of the above	☐ Other: _____		

VACCINE INFORMATION AND FACT SHEETS

The ☐Moderna ☐Johnson & Johnson COVID-19 vaccine has been authorized by the Food and Drug Administration (FDA) under an Emergency Use Authorization (EUA) in response to the ongoing COVID-19 Pandemic. The COVID-19 vaccine has not been fully approved but is being made available under an EUA due to scientific evidence supporting the safety and efficacy of the COVID-19 vaccine and the vaccine's highly favorable risk-benefit ratio. Please scan the QR code to the right to read the FDA EUA Fact Sheet for the appropriate vaccine.

In order to optimize vaccine response, you will receive ☐ 1 dose ☐ 2 dose(s) 28 days apart.

CONSENT FOR VACCINE

I have reviewed the Emergency Use Authorization face sheet provided to me today. I have had the opportunity to discuss my concerns with the doctor. I have been advised to remain on site for 15 minutes after receiving the vaccine and have agreed to notify the medical staff if I experience any adverse effects after leaving. I understand that my information and vaccination status will be reported to the state. I understand the benefits and risks of the vaccine and freely and voluntarily request to receive the COVID-19 vaccine.

_____ _____
Signature of Patient, Parent, or Legal Guardian Date

FOR ADMINISTRATIVE USE ONLY

Manufacturer: ☐ Moderna ☐ Johnson & Johnson	Exp. Date:	Route IM: ☐ Right Deltoid ☐ Left Deltoid	Time/Date Vaccine Given:	☐ Entered Into ImmTrac 2
Lot #:			Signature of Vaccine Administrator:	By:_____