COVID-19 Vaccine Consent Form

Section 1: Patient Information

NAME (Last)	(First)	DATE OF BIRTH	GENDER
ADDRESS			
CITY	STATE	ZIP	DAYTIME PHONE NUMBER
PRIMARY CARE PHYSICIAN: Name	Address		Phone Number
MOTHER'S MAIDEN NAME: (required by DHEC)	RACE:		
EMERGENCY CONTACT: Name	Relation		Phone Number

IS THIS YOUR FIRST • SECOND • THIRD • FOURTH • OTHER • DOSE OF THE COVID-19 VACCINE? (circle one)
If this is not your first dose, what was the date(s) of your previous dose(s)? _____
Manufacturer of previous dose(s)? _____

Section 2: Screening Questions

	YES	NO
1. Do you have any allergies? This would include food, pet, environmental, or medications allergies. Please list:		
2. Are you feeling sick today? (For example, cold, fever, or acute illness)		
3. Do you have a bleeding disorder or are you on a blood thinner?		
4. Are you immunocompromised or are you on a medicine that affects your immune system?		
5. Are you pregnant or breastfeeding?		
6. Have you ever had an allergic reaction after receiving a vaccine? If so, what type of reaction?		
7. Have you ever had an allergic reaction to a component of the COVID-19 vaccine including polyethylene glycol (PEG) or Polysorbate?		
8. Have you received any vaccines in the last 14 days? If so, list here:		
9. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?		
10. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		

Section 3: Consent

• I have been given a copy and have read, or have had explained to me, the information in the **FACT SHEET** for the COVID-19 vaccine. I understand the FDA has authorized the emergency use of the COVID-19 vaccine, which is not an FDA-approved vaccine. I have had the chance to ask questions that were answered to my satisfaction.

• I understand the COVID-19 vaccine may require 2 doses. If this is my first dose of the COVID-19 vaccine, I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the vaccination series, if necessary.

• I understand the significant known and potential risks and benefits of the COVID-19 vaccine as explained in the FACT SHEET and that some potential risks and benefits may remain unknown, and **I REQUEST THE COVID-19 VACCINE BE GIVEN TO ME.**

• I agree to stay in the vaccine administration area for fifteen (15) minutes (or longer if indicated by the vaccine administrator) after receiving my vaccination to ensure that no immediate adverse reactions occur, and I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician.

SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT (if applicable) _____ **DATE:** _____

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Signature of Vaccine Administrator
COVID-19	_____ml • Dose # ____	IM - L Arm IM - R Arm		Moderna Janssen Pfizer			

Name/Title of Immunizer _____ Supervising Pharmacist (if applicable)_____

License #: _____