COVID–19 Vaccination Consent Form

COVID-19 VACCINE:

COVID-19 vaccines will help prevent a disease that can be dangerous, or even deadly. Authorized or approved vaccines will help reduce the risk of disease by working with the body's natural defenses to safely develop protection (immunity) to disease. COVID-19 vaccines help our bodies develop immunity to the virus that causes COVID-19 without us having to get the illness. It typically takes a few weeks for the body to develop immunity to the virus after vaccination. Therefore, it is possible that a person could be infected with the virus that causes COVID-19 just before or just after vaccination and then get sick because the vaccine did not have enough time to provide protection.

Sometimes after vaccination, the process of building immunity can cause symptoms, such as fever. These symptoms are normal and are a sign that the body is building immunity. The vaccine is NOT a live virus and will not give you COVID-19.

RISKS & POSSIBLE SIDE EFFECTS:

COVID-19 vaccines have shown to generally cause only mild side effects. Most commonly, reactions may be soreness or tenderness at the injection site, fever, chills, fatigue, headaches or muscle aches. These effects usually last 24 to 48 hours. There is a possibility, as with any vaccine or drug, that an allergic or other serious reaction, or even death, could occur. Moreover, medical events completely unrelated to vaccine administration may occur coincidentally in the period following vaccination.

At this time, the COVID–19 vaccine may not be recommended for certain individuals due to age thresholds or other specific conditions based on the FDA Emergency Use Authorization Patient Fact Sheets. Please review the manufacturer FDA EUA Patient Fact Sheets for a full list of contraindications and precautions.

If any contraindication within the FDA EUA Patient Fact Sheet applies to you, please notify the staff. If you have any questions, please ask now or check with your physician or health department before receiving the vaccine.

IF YOU EXPERIENCE ANY SIGNIFICANT REACTIONS, CONTACT YOUR PHYSICIAN.

I have read the above information about COVID-19 and the COVID-19 vaccine EUA Patient Fact Sheet with patient education information, and I have had a chance to ask questions. I understand the benefits and risks of the COVID–19 vaccination and request that the vaccine be given to me.

PATIENT NAME (Please Print) DATE OF BIRTH

PHONE NUMBER

SIGNATURE (patient or parent/guardian if under 18 years of age) DATE/TIME

Created: 11/3/2021 v8
For additional information: https://www.cdc.gov/coronavirus/2019-ncov/vaccines

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Name:						
Address:						
Street		City		State		Zip
County						
Birthdate: / /			**Phone Number:**			
Month Day Year						
RACE: check one or more	☐ American Indian or Alaska Native	☐ Asian	☐ Black or African American	☐ Native Hawaiian or other Pacific Islander	☐ White	☐ Other
Ethnicity:	Hispanic or Latino		**Sex:**	☐ Female	☐ Male	
	☐ Yes	☐ No				

For Facility Use Only:

COVID-19 Vaccine Manufacturer	ADMINISTRATION		
		First Dose	
		Lot #:	Exp. Date:
		Site (IM):	Administered by:
		Date:	Time:
		Second Dose	
		Lot #:	Exp. Date:
		Site (IM):	Administered by:
		Date:	Time:
		Third Dose	
		Lot #:	Exp. Date:
		Site (IM):	Administered by:
		Date:	Time:
		Booster Dose	
		Lot #:	Exp. Date:
		Site (IM):	Administered by:
		Date:	Time:

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