Vaccine Consent Form

Please PRINT legible

Office Use: Temp _____

☐ Employed ☐ Individual 18 and up ☐ Individual under 18

Employer Name:_____Job Title: _____

LEGAL Name:_____Date of Birth:_____E# or DR#:_____
on back of ID badge

Address:_____Email: _____
Street or P O Box City State Zip Code

Telephone #:_____Allergies: _____

	Medical History (All Vaccines)	Yes	No	Don't Know
1.	Are you sick today?			
2.	Do you have allergies to latex, food, medication, or vaccine components? (Examples: eggs, thimerosal, gelatin, neomycin, phenol, or bovine protein)? If yes, please specify:			
3.	Have you ever had a serious reaction after receiving a vaccine?			
4.	In the past 14 days, have you received any other immunizations/vaccine?			
5.	Have you had a seizure or any brain or other nervous system problem (i.e.: Guillain Barre Syndrome)?			
6.	For Women: Are you pregnant or considering becoming pregnant in the next 3 months?			

I have been provided with the vaccine information sheet/s corresponding to the vaccine/s I am receiving. I have read the information about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risk of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand I must remain in the vaccine administration area for the recommended observational period of 15 to 30 minutes after the vaccination to be monitored for any potential adverse reactions.

Signature: _____Date: _____VIS Date: _____

Parent/Guardian Signature (under age 18) : _____Date:_____

	COVID Screening Questions (All Vaccines)	Yes	No	Don't Know
1.	In the last month have you been in direct contact with someone who was confirmed or expected to have the coronavirus/COVID-19?			
2.	Do you have any of the following symptoms:			
	• Cough/cold/fever/shortness of breath or flu like symptoms?			
	• Sore throat /loss of smell or taste?			
	• Abdominal pain or diarrhea?			
	• Abnormal bruising or bleeding/eye redness?			
3.	Any international travel in the past month?			
4.	In the past 90 days, have you tested positive for COVID-19 or are you currently being monitored for COVID-19? If yes, did you receive monoclonal antibody infusion?			

Vaccine: COVID-19 Manufacturer: Pfizer Lot #:_____ Exp Date:_____

Dose: 0.3 ml Administration Route: ☐ IM ☐ SQ Site: Deltoid: ☐ L ☐ R Arm: ☐ L ☐ R

Administered by: _____ Date: _____ Time: _____

Reaction? ☐ Yes ☐ No Date: _____ Time: _____ Signature: _____

☐ _____(*initial*) I elect not to wait for the recommended observational period. I hereby waive all claims for personal injury or death and release Infirmary Health from any and all liability for personal injury or death relating to my decision to leave without observing the recommended observational period.