COVID-19 Vaccine Consent Form

Last Name	*First Name*	*MI*	*Date of Birth* / /	*Gender*

Home Address	*City*	*State*	*ZIP*	*Phone Number* ( ) ☐ Home ☐ Mobile

COVID-19 VACCINE SCREENING QUESTIONNAIRE

1. Are you feeling sick today? YES / NO

2. Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? YES / NO

   ☐ Pfizer ☐ Moderna ☐ Another product _____

3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)

   - A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures YES / NO
   - Polysorbate YES / NO
   - A previous dose of COVID-19 vaccine YES / NO

4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? YES / NO

5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies. YES / NO

6. Have you received any vaccine in the last 14 days? YES / NO

7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? YES / NO

8. Have you received passive antibody therapy (*monoclonal antibodies* or *convalescent serum*) as treatment for COVID-19? YES / NO

9. Do you have a weakened immune system caused by something such as HIV infection or cancer, or do you take immunosuppressive drugs or therapies? YES / NO

10. Do you have a bleeding disorder or are you taking a blood thinner? YES / NO

11. Are you pregnant or breastfeeding? YES / NO

CONSENT FOR VACCINATION(S) – YOU MUST AGREE TO BELOW FOR YOU/YOUR FAMILY TO BE VACCINATED

Health care services are confidential. No information is released without your consent except as may be required under public health and safety laws. Information used for evaluation and planning purposes never includes personal identifiers. To access a digital copy of DHSS notice of privacy practices please go to the following website: http://dhss.alaska.gov/dph/Nursing/Documents/Registration%20Forms/DHSS_Notice_of_Privacy_Practices.pdf
By completing this form, I am acknowledging Informed Consent. **Please read and sign.** My signature below indicates that:

- I have voluntarily chosen to receive the vaccination and consent to the administration.
- I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient or am authorized to consent on behalf of the client.
- I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") provided for the vaccine(s) to be administered.
- I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.
- I understand the benefits and risks of the vaccine(s).
- I will immediately alert the provider of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine.
- I understand I should remain in the area for 15 minutes after the vaccination for observation or 30 minutes if I have any history of severe allergic reaction or anaphylaxis.

X _____ _____

Signature of Patient, or Parent / Guardian of Minor Patient *Date*