COVID-19 VACCINE CONSENT FORM - KUD

PATIENT NAME_____

DATE OF BIRTH_____

PHONE_____ **MOTHER'S MAIDEN NAME**_____

ADDRESS_____ **CITY**_____ **STATE**_____ **ZIP**_____

GENDER: M ☐ **F** ☐ **HISPANIC/LATINO?** Y ☐ N ☐

RACE: WHITE ☐ ASIAN ☐ BLACK ☐ PACIFIC ISLANDER ☐ NATIVE AMERICAN ☐ OTHER ☐

1. Are you feeling sick today? ..... Y ☐ N ☐

2. Have you ever received a dose of COVID-19 vaccine? ..... Y ☐ N ☐

- If yes, which vaccine product did you receive?
  ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product _____
- Have you received a complete COVID-19 vaccine series
  (i.e., 1 dose Janssen [J&J] or 2 doses mRNA [Pfizer-Biontech, Moderna])? ..... Y ☐ N ☐

3. *Have you had an allergic reaction to:

- 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 ..... Y ☐ N ☐
  - Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids ..... Y ☐ N ☐
- A previous dose of COVID-19 vaccine ..... Y ☐ N ☐

4. *Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? ..... Y ☐ N ☐

5. Check all that apply to you:

☐ Am a female between ages 18 and 49 years old
☐ Am a male between the ages 12 and 29 years old
☐ Have a history of myocarditis or pericarditis
☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
☐ Have a bleeding disorder
☐ Take a blood thinner
☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
☐ Have a history of heparin-induced thrombocytopenia (HIT)
☐ Am currently pregnant or breastfeeding
☐ Have received dermal fillers
☐ Have a history of Guillain-Barré Syndrome (GBS)
☐ None of the above

*For questions 3 and 4: allergic reaction 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 that caused hives, swelling, or respiratory distress, including wheezing.

Consent for Treatment and Privacy Notice

I certify that the information I have provided is true and accurate. I have had a chance to review the Covid-19 vaccine Information (EUA Fact Sheet) and consent to receive the vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine. I understand and agree that information related to my vaccine administration may be recorded in the Utah Statewide Immunization Information System (USIIS). I hereby release Southwest Utah Public Health Department (SWUPHD), and its employees, from all claims arising from such immunizations. We are required to inform you of our privacy practices for the information we collect and keep about you. I have been given a copy of the Health Department's Notice of Privacy Practices and have had an opportunity to ask questions about how my information may be used.

Signature:_____ Date: _____

Relationship to Client: Self ☐ Parent ☐ Legal Guardian ☐ Other ☐ _____

FOR BOOSTER DOSE, PLEASE SEE BACK

FOR COVID-19 BOOSTER DOSE

IF YOU ARE RECEIVING A COVID-19 BOOSTER DOSE AND ARE UNDER 65 YEARS OLD, PLEASE ANSWER THE FOLLOWING:

1. **WHEN DID YOU RECEIVE YOUR LAST COVID-19 DOSE?**_____

2. **DO YOU WORK IN A HIGH RISK ENVIRONMENT?.....Y⬜ N⬜**
   IF YES, PLEASE INDICATE WHAT YOUR OCCUPATION IS IN THE SPACE BELOW:

(I.E., 1ST RESPONDER [HEALTHCARE, FIREFIGHTERS, POLICE, CONGREGATE CARE STAFF], EDUCATION STAFF, FOOD & AGRICULTURE WORKER, MANUFACTURING WORKER, CORRECTIONS WORKER, US POSTAL SERVICE WORKER, PUBLIC TRANSIT WORDER, GROCERY STORE WORKERS)

3. **DO YOU HAVE A MEDICAL CONDITION THAT PLACES YOU AT HIGHER RISK?** .....Y⬜ N⬜
   IF YES, PLEASE INDICATE WHAT YOUR MEDICAL CONDITION IS IN THE SPACE BELOW:

(I.E., CANCER, CHRONIC KIDNEY, LIVER, OR LUNG DISEASE, DEMENTIA OR OTHER NEUROLOGICAL CONDITIONS, DIABETES, DOWN SYNDROME, HEART CONDITIONS, HIV, WEAKENED IMMUNE SYSTEM, MENTAL HEALTH CONDITIONS, OVERWEIGHT/OBESITY, PREGNANCY, SICKLE CELL/THALASSEMIA, SMOKING [CURRENT OR FORMER] ORGAN/BLOOD STEM CELL TRANSPLANT, STROKE, SUBSTANCE USE DISORDERS,TUBERCULOSIS)

FOR PHARMACIST USE ONLY

Date	Mfr	Lot #	Exp.	Dose	Route	Deltoid	Vaccinator
					IM	☐ Right ☐ Left	