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Ht: _____ Wt: ______		
DOB: ____________		
Inititals: ___________		

COVID-19 Vaccine Consent Form

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked.

#	Question	YES	NO	I Don't Know
1	Are you feeling sick today?			
2	Have you ever received a dose of COVID-19 vaccine?			
	If YES, which product did you receive? □ Moderna	□ Pfizer		□ Other
3	Have you ever had an allergic reaction to one of the following: (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 previous dose of COVID-19 Vaccine			
	• Polysorbate			
	• Polyethylene glycol (PEG) a component of the Covid-19 Vaccine			
4	Have you ever had an allergic reaction to other vaccines or an injectable medication?			
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? Including food, pets, environmental or oral medication allergies.			
6	Have you received any vaccines in the last 14 days?			
7	Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9	Have you been informed that the COVID-19 Vaccine is an unapproved vaccine that has been authorized for use by the FDA under the Emergency Use Authorization?			
10	Have you received the "Facts Sheet for Recipients and Caregivers" along with the V-Safe app information?			

________ I have made an informed decision to receive the COVID-19 Vaccine.
Initials

______________________________ ______________________________
Patient/Caregiver Printed Name Date

______________________________ ______________________________
Patient/Caregiver Signature Witness' Signature

Reference: CDC Prevaccination Checklist for COVID-19 Vaccines