DEWITT PIATT BI–COUNTY HEALTH DEPARTMENT COVID-19 VACCINATION CONSENT FORM

PLEASE PRINT CLEARLY

NAME: _____ BIRTHDATE: _____ AGE: _____

MAILING ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____ EMAIL: _____

RACE: _____ GENDER: _____

HISPANIC OR LATINO (circle one): YES___ NO___

OCCUPATION: _____ RETIRED (circle one): YES___ NO___

PHYSICIAN: _____

EMERGENCY CONTACT + PHONE NUMBER: _____

**Please answer the following questions, then sign and date the appropriate lines.**

***If consent is completed by someone other than the person receiving the vaccine, please provide name and number:** Name:_____ Phone Number:_____

| | | |
|---|---|---|
| Are you currently sick or have a fever? | YES___ | NO___ |
| Are you under the age of 18? | YES___ | NO___ |
| Have you ever been diagnosed with COVID19? When?_____ | YES___ | NO___ |
| If so, did you receive COVID-19 specific treatment? Type:_____ | YES___ | NO___ |
| How many COVID19 vaccinations have you received prior to today?_____ | | |
| Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a vaccine or injectable medication? (^This would include food, pet, venom, environmental, or oral medication allergies) | YES___ | NO___ |
| Do you have a history of Guillain-Barré syndrome? | YES___ | NO___ |
| Do you currently have or have a history of cancer, leukemia, HIV/AIDS or other immune system deficiencies? | YES___ | NO___ |
| Do you have an underlying health condition such as asthma, lung disease, heart disease, kidney disease, metabolic disease (diabetes), neuromuscular disease, or a blood disorder? | YES___ | NO___ |
| Do you take aspirin every day? | YES___ | NO___ |
| In the past 3 months, have you taken immunosuppressive therapeutics? -Examples: steroids such as prednisone, anti-cancer drugs, anti-viral meds, or radiation treatments. | YES___ | NO___ |
| Are you currently breastfeeding, pregnant, or could become pregnant In the next month? | YES___ | NO___ |
| Have you had any other vaccinations within the past 4 weeks? | YES___ | NO___ |

I HAVE READ THE INFORMATION OR HAVE HAD THE INFORMATION EXPLAINED TO ME. I HAVE HAD A CHANCE TO ASK QUESTIONS AND THESES HAVE BEEN ANSWERED TO MY SATISFACTION. I UNDERSTAND THE BENEFITS AND RISKS OF COVID-19 VACCINE AND ASK THAT THE VACCINE BE GIVEN TO ME, OR TO THE PERSON NAMED ON THE CONSENT FOR WHOM I AM AUTHORIZED TO MAKE THIS REQUEST. I ACCEPT RESPONSIBILITY FOR SEEKING MEDICAL ATTENTION FOR ANY PROBLEMS WITH THIS VACCINATION. I ACKNOWLEDGE I HAVE RECEIVED, OR REQUESTED, A COPY OF THE DEWITT PIATT BI-COUNTY HEALTH DEPARTMENT NOTICE OF PRIVACY PRACTICES. I AGREE TO WAIT A MINIMUM OF 15 MINUTES AFTER VACCINE IS GIVEN TO MONITOR FOR SIGNS AND SYMPTOMS OF ADVERSE REACTION. I CONSENT TO HAVE THE COVID-19 VACCINE ADMINISTERED. I CONSENT TO HAVE AMY VACCINATION RECORDED IN THE STATE OF ILLINOIS REGISTRY SYSTEM I-CARE.

X_____ X_____

*^^ AUTHORIZING SIGNATURE ^^* *^^ DATE ^^*

*STOP HERE.*

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*FOR OFFICE USE ONLY.*

EAU/VIS PROVIDED (circle one):

MODERNA (red top)

PFIZER-12 years and older (purple top)

PFIZER-5 years old to 11 years (orange top)

Janssen (J&J)

SITE/ROUTE GIVEN (circle one): ARM: R. DELTOID-IM L.DELTOID-IM

THIGH: R. VASTUS LATERALIS-IM L. VASTUS LATERALIS-IM

MANUFACTURER:_____ AMOUNT GIVEN (in mL):_____

LOT NUMBER:_____ EXP. DATE: _____

REACTION? YES____ NO____ If applicable: DILUENT LOT# & Exp. Date _____

Vaccination Complete (mark one)?

o Completed o Refused o Not administered o Partially administered

ADMINSITERED BY:_____ DATE: _____