DeWitt-Piatt
Bi-County Health Department

PREVENT • PROMOTE • PROTECT

www.dewittpiatthealth.com

COVID-19 VACCINATION CONSENT FORM: PLEASE PRINT CLEARLY

NAME: _____ **BIRTHDATE:** _____ **AGE:** _____

MAILING ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____ **EMAIL:** _____

RACE: _____ **GENDER:** _____

ETHNICITY (circle one): Hispanic/Latino Non-Hispanic/Non-Latino **Other:** _____

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 print name and phone number here:** _____

Are you currently sick or have a fever?	YES___	NO___
Have you ever been diagnosed with COVID19 in the last 6 months?	YES___	NO___
If so, did you receive COVID-19 specific treatment? Type:_____	YES___	NO___
Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a vaccine or injectable medication?	YES___	NO___
(^This would include food, pet, venom, environmental, or oral medication allergies)		
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?	YES___	NO___
(^Examples: steroids such as prednisone, anti-cancer drugs, anti-viral meds, or radiation treatments.)		
Have you had any other vaccinations within the past 4 weeks?	YES___	NO___

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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.

FOR OFFICE USE ONLY.

EUA/VIS PROVIDED (circle one): **MODERNA** **PFIZER**

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:** _____

***(If applicable)*: DILUENT LOT# & Exp. Date** _____

REACTION? **YES**____ **NO**____

Vaccination Complete (mark one)?

o Completed o Refused o Not administered o Partially administered

NOTES (optional):_____

ADMINSITERED BY:_____ **DATE:** _____