COVID19 VACCINATION
CONSENT
DEWITT- PIATT BI-COUNTY HEALTH DEPARTMENT

PLEASE PRINT CLEARLY!

NAME:_____ BIRTH DATE:_____ AGE_____
(Person receiving vaccination – Name must match Medicare, Insurance or Medicaid Card)

MAILING ADDRESS:_____

CITY/STATE/ZIP:_____

Email address:_____

PHONE:_____ **GENDER: MALE FEMALE (circle one)**

Race: _____ **Ethnicity** _____

Occupation: _____ **Retired: YES No (circle one)**

PHYSICIAN: _____

EMERGENCY CONTACT: _____

Is the client currently sick or have a fever? **Yes ____ No ____**

Have you been diagnosed with COVID19? When? _____ **Yes ____ No ____**

Did the client receive a COVID19 vaccination prior to today? Moderna or Pfizer? **Yes ____ No ____**

Has client ever had an allergic (anaphylactic) reaction to something, or to the COVID19 vaccine or other vaccines? **Yes ____ No ____**

Does client have a history of Guillain Barre syndrome **Yes ____ No ____**

Is the person to be vaccinated younger than age 16 or 18? **Yes ____ No ____**

Does the client have cancer, leukemia, HIV/AIDS or other immune system problems? **Yes ____ No ____**

Does the client have a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (diabetes), neuromuscular disease, or a blood disorder? Is he/she on long term aspirin therapy? **Yes ____ No____**

In the past 3 months has the client taken Prednisone, other steroids, drugs for rheumatoid arthritis, Crohn's disease, or psoriasis, or anti-cancer drugs, anti-viral meds, or radiation treatments? **Yes ____ No ____**

Is the client breastfeeding, pregnant or could become pregnant in the next month? **Yes ____ No ____**

Has the client received vaccinations in the past 4 weeks? **Yes ____ No ____**

Have you received passive antibody therapy as treatment for COVID19 **Yes ____ No ____**

I have read the information or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of COVID19 vaccine and ask that the vaccine be given to me, or to the person named above 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 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 my vaccination recorded in the State of Illinois registry system I-Care.

X_____ X_____

AUTHORIZING SIGNATURE *DATE*

For office use only below

EAU GIVEN:

_____ **Fact Sheet for Recipients and Caregivers Emergency use Authorization of the Moderna COVID-19 Vaccine**

_____ **Pfizer-BioNTech COVID19 Fact Sheet for Recipients and Caregivers Emergency use Authorization of the Pfizer-Biotech COVID-19 Vaccine**

ROUTE GIVEN IM

SITE: R. DELTOID/THIGH_____ **L. DELTOID/THIGH**_____

ADMINISTERED BY: _____ **DATE:** _____

Lot # _____ **Manfacturer**_____ **Exp. Date**_____

COVID19consents:tc12/20:01/21