

**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:** \_\_\_\_\_ **Circle one:** Non-Hispanic Hispanic Latino

**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?** 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 any other vaccinations (other than COVID) recently?** 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*  
*(Parent or guardian if under age 18)*

*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 # \_\_\_\_\_ Manufacturer \_\_\_\_\_ Exp. Date \_\_\_\_\_

COVID19consents:tc12/20:01/21:02/21