**COVID-19 Vaccine Consent form **

|  |  |
| --- | --- |
| **Name (Last, First, MI)** | **DOB:** / / |
| **Address** | **Age:** |
| **City/State/ZIP** | |
| **Phone** | |

Your primary care doctor/provider’s name, city, state: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Required by the State of Illinois:**

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| --- |
| **Race:**  Hispanic/Latino 𑂽 Not Hispanic/Latino 𑂽 Unknown 𑂽  **Ethnicity:**  American Indian/Alaska Native 𑂽 Asian 𑂽 Black/African American 𑂽 Hispanic/Latino 𑂽 Native Hawaiian/Pacific Islander 𑂽 Other Race 𑂽 Unknown 𑂽 White 𑂽 |

**YES NO**

|  |  |  |
| --- | --- | --- |
| Have you ever had a serious reaction to a vaccine or other injectable drug, if yes, which medication and what was the reaction?  Allergy to Polysorbate or PEG, if yes, what was the reaction? | **𑂽** | **𑂽** |
| Do you have any other serious allergies? Please list: | **𑂽** | **𑂽** |
| Have you received a previous single dose or 2-dose series of a COVID-19 vaccine?  If yes, number of doses and brand of vaccine: | **𑂽** | **𑂽** |
| Are you able and willing to remain onsite for 15-30 minutes after your vaccine? | **𑂽** | **𑂽** |
| Have you received or plan on receiving any vaccinations within the past or next two weeks? | **𑂽** | **𑂽** |

**𑂽 I have read or had explained to me the COVID-19 Vaccine EUA Fact sheet and understand the risks and benefits. I GIVE CONSENT to the Rock Island County Health Department authorized employee or designee to administer the COVID-19 Vaccination.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaccine recipient (or Parent/Guardian, if applicable)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Vaccination Record (FOR ADMINISTRATIVE USE ONLY)**

EUA provided: Y / N Vaccination Card provided: Y / N If vaccine deferred, please state reason:

|  |
| --- |
| **Temperature:** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Vaccine: COVID-19 | Route:  IM Deltoid | Date Administered | Manufacturer | Lot Number | Name & Title of person administering vaccine |
| Dose #1 | L R |  | Pfizer Moderna |  |  |
| Dose #2 | L R |  | Pfizer Moderna |  |  |

  Updated 02/10/2021 version 1.4