COVID-19 Consent for Vaccination

PLEASE PRINT

Patient *FIRST* Name:	***LAST* Name**:	**MI**:
Maiden Name (Optional):		
DOB: / /	**Current Age**:	**Sex**: ☐ F ☐ M ☐ Other
Race: ☐White ☐Black or African American ☐Asian ☐American Indian or Alaskan Native ☐Other ☐Native Hawaiian or Other Pacific Islander ☐Unknown		
Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Unknown		
Address:	**City**: **State**:	**Zip**:
Cell Phone: ( )	**Alternate Phone:** ( )	
Tier: (Circle One) **1A1** **1A2** **1B** **1C** **Based on Age**		

The following questions will help determine if there is any reason you should not receive a COVID immunization injection. <u>Questions should be answered for the person who will be vaccinated</u>.

If a question is not clear, please ask a healthcare provider to explain.

1.	Younger than 16 years old? (Must be 16 or older to receive Pfizer)	☐ Yes	☐ No
2.	Younger than 18 years old? (Must be 18 or older to receive Moderna).....	☐ Yes	☐ No
3.	History of any immediate allergic reaction, of any severity, after a previous dose of mRNA COVID-19 vaccine or any of its components (including polyethylene glycol [PEG]) or polysorbate?..... **Cause/Allergy:** _____	☐ Yes	☐ No
4.	History of immediate allergic reaction of any severity to any substance?..... **Cause/Allergy:** _____	☐ Yes	☐ No
5.	Ever received a COVID-19 vaccine?..... **Date:** _____ **Manufacturer:** _____	☐ Yes	☐ No
6.	Sick today, including symptomatic/asymptomatic infection with COVID-19?.....	☐ Yes	☐ No
7.	Received passive antibody therapy for COVID-19 in the last 90 days?.....	☐ Yes	☐ No
8.	Received any vaccine in the past 14 days?.....	☐ Yes	☐ No
9.	Pregnant or breastfeeding?.....	☐ Yes	☐ No

Request for Administration of COVID-19 Vaccine for the above-named recipient: I acknowledge that I have received the Vaccine Information Statement or Emergency Use Authorization Information Sheet and the Tennessee Department of Health's Notice of Privacy Practices. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I am aware that, to provide protection against the virus that causes COVID-19, two doses of this same vaccine may be required. I acknowledge that I may receive a reminder for a second dose by text (if cell phone number provided, standard messaging rates may apply), phone call, or mail.

PATIENT/PARENT OR GUARDIAN/POWER OF ATTORNEY SIGNATURE: _____ DATE: _____

This consent is valid for 12 months from date signed.

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[Enter County] County Health Department

Vaccination Site Location [address]_____

AREA FOR OFFICIAL USE ONLY
Nursing Immunization **[INJECTION #1]** Documentation

Manufacturer: Pfizer Moderna

Dose: 0.3 mL / 0.5ml **Route**: IM

Site Administered: ☐Right Deltoid ☐Left Deltoid ☐[Other]

Lot Number: _____ **Expiration Date: / /** **EUA Date:** 12**/**2020

Date Given: / / **Provider number:** _____ (Optional)

Signature: _____
Signature indicates immunization given according to PHN Protocol

☐Vaccine NOT given secondary to contraindication:

☐Verbal Order obtained from _____ to proceed with immunization per protocol; readback completed. Special Instructions:
PHN Signature:

AREA FOR OFFICIAL USE ONLY
Nursing Immunization **[INJECTION #2]** Documentation

☐All initial screening questions have been reviewed and discussed.

Manufacturer: Pfizer Moderna

Dose: 0.3 mL / 0.5ml **Route**: IM

Site Administered: ☐Right Deltoid ☐Left Deltoid ☐[Other]

Lot Number: _____ **Expiration Date: / /** **EUA Date:** 12**/**2020

Date Given: / / **Provider number:** _____ (Optional)

Signature: _____
Signature indicates immunization given according to PHN Protocol

☐Vaccine NOT given secondary to contraindication:

☐Verbal Order obtained from _____ to proceed with immunization per protocol; readback completed. Special Instructions:
PHN Signature: