CIRCLE ONE:	
1st DOSE	2nd DOSE

Clark County Health Department
COVID-19 Vaccine Consent Form

NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH** month_____ day_____ year _____ Age ____
ADDRESS			**DAYTIME PHONE NUMBER:**
CITY	**STATE**	**ZIP**	**PHYSICIAN:**
RACE (Please Circle): American Indian or Alaska Native, Asian, Black or African-American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other Race, White, Unknown			**ETHINICITY (Please Circle):** Hispanic or Latino, Not Hispanic or Latino, Unknown

	YES	NO
1. Are you feeling sick today? (e.g., cold, fever, acute illness?) *Defer vaccination until after illness*		
2. **Have you experienced a severe allergic reaction to any vaccine or an injectable medication? Or something else such as food, pet environmental or oral medication allergies (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) ****If yes, a physician consult is necessary prior to taking vaccine.**		
3. In the past two weeks, have you received any vaccinations? **If yes, defer vaccination until >14 days**		
4. Are you pregnant or breastfeeding? If so, have you been counseled by an Obstetrician and/or Pediatrician prior to receiving the COVID-19 vaccine?		N/A
5. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		
6. Are you currently under quarantine due to COVID-19 exposure?		
7. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as part of COVID-19 treatment? (COVID-19 Vaccine should be deferred for at least 90 days)		
8. Have you received a COVID-19 vaccine? If yes, what brand of COVID-19 vaccine have you been vaccinated for? **CIRCLE THE BRAND:** Pfizer Moderna Janssen (J&J)		
9. Do you have a bleeding disorder or are you on a blood thinner?		
10. Are you immunocompromised or are you on a medicine that affects your immune system? ****If yes, a physician consult is necessary prior to taking vaccine**		

CONSENT FOR VACCINATION:

The purpose of the COVID-19 virus vaccine is to reduce the likelihood of contracting COVID-19. **While the FDA has not approved and continues to evaluate its safety and effectiveness, the FDA has authorized the emergency use of it to prevent COVID 19.**

All vaccines have risks. Possible side effects of the COVID 19 vaccine, while generally inconsequential in adults, can include:

1. Pain, redness or swelling around the vaccination site.
2. Fever, malaise, headache, fatigue, chills, joint pain, muscular aches, nausea and vomiting. There is a remote risk of a severe allergic reaction.
3. There may be risks that are not yet known. The FDA continues to evaluate the vaccine and the known side effects are limited based on current data. Additional side effects may become known as the vaccine is used more widely.

I consent to the administration of the COVID-19 virus vaccine by intramuscular injection. I have read the above statement pertaining to COVID-19 virus vaccine and the Fact Sheet from the manufacturer. I have been advised of and understand the risks, side effects, benefits and alternatives to receiving the vaccine. I understand that there may be risks that are not yet known and other remote risks. I understand the conditions under which the vaccine should not be administered and am unaware of the presence of any of these conditions in myself. I have been advised and understand the Pfizer and Moderna vaccines are a series of two injections, and I intend to complete the series of vaccinations. **I understand that I am receiving the vaccine voluntarily and that I have the option to accept or refuse the COVID-19 vaccine at any time, for any reason. I understand that I will not realize the benefit of the vaccine if I decline to receive the second injection.** (Janssen/Johnson &Johnson is a single dose vaccine.)

- I have been provided information on V-Safe, a safety monitoring smartphone-based tool managed by CDC**.**
- I consent to allow information on this form, as well as the patient registration form, to be entered as necessary in the Illinois Immunization Registry (ICARE).
- I authorize Clark County Health Department to release information regarding my vaccinations to my physician.
- I have had the opportunity to review the Notice of Privacy Practices

Signature: _____ **Date: (month ____ day ____ year 202___)**

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Given	Route	Site	Manufacturer	Lot No. \ Exp Date	Name and Title of Administrator
COVID-19		IM	R deltoid L deltoid			