CIRCLE ONE:

1st DOSE 2nd DOSE 3rd DOSE BOOSTER

Clark County Health Department

COVID-19 Vaccine Consent Form

Name (Last)	(First)	(MI)	**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 Latina, Native Hawaiian or Other Pacific Islander, Other Race, White, Unknown			**Ethnicity (Please Circle)**: Hispanic or Latino, Non-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 hive, swelling, or respiratory distress, including wheezing.) ****If yes, a physician consult is necessary prior to taking vaccine.**		
3. 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
4. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		
5. Are you currently under quarantine due to COVID-19 exposure?		
6. Have you received a COVID-19 vaccine? **Circle the Brand:** If yes, what brand of COVID-19 vaccine have you been vaccinated for? *Pfizer* *Moderna* *Janssen (J&J)*		
7. Do you have a bleeding disorder or are you on a blood thinner?		
8. Are you immunocompromised or are you on medicine that affects your immune system?		

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** (except Pfizer vaccine 18+ years is FDA 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 COVID19 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
- I authorize Clark County Health Department to release service-related information regarding the above mentioned to a third-party payor and to bill for services rendered to me if applicable. I request my payor to pay CCHD directly for services rendered to me

Insured Name_____ **Date of Birth** _____

Signature: _____ **Date: (Month ____ Day _____ Year 202 __)**

FOR ADMINISTRATIVE USE ONLY

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