COVID-19 VACCINE CONSENT FORM

Section 1: Information About Person to Receive Vaccine

Name _____ Date of Birth _____

Section 2: Screening for Vaccine Eligibility

_____("Provider") offers the **COVID-19 Vaccine**. The following questions will help us know if you are eligible for the **COVID-19 Vaccine**. If you answer **NO** to all four of the following questions, you are eligible for the **COVID-19 Vaccine**. If you answer **YES** to one or more of the following questions, you may not be eligible for the **COVID-19 Vaccine**. Please mark **YES** or **NO** for each question.

	YES	NO
1. Do you have allergies to latex, medications, food, or vaccines (e.g., eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, or thimerosal)?		
2. Do you have any other serious allergies? Please list:_____		
3. Have you ever had a serious reaction after receiving a vaccine?		
4. Have you ever had Guillain-Barré Syndrome, a seizure disorder, brain disorder, or other nervous system problem?		
5. **For Women:** Are you pregnant or a chance you will become pregnant in the next month?		

Section 3: Consent for Vaccination

I have read or had explained to me the CDC Vaccine Information Fact Sheet for the **COVID-19 Vaccine** and understand the risks and benefits.

[ ] I consent to receive the **COVID-19 Vaccine**.

[ ] I consent to receive the **COVID-19 Vaccine** at another time.

[ ] I do not consent to receive the **COVID-19 Vaccine**.

[Signature on Following Page]

By signing below, I acknowledge that I have received information on the **COVID-19 Vaccine**, including the CDC Vaccine Information Statement, and why the **COVID-19 Vaccine** is recommended at this time. Acknowledging that this information has been provided to me, I understand the risks versus the benefits of the **COVID-19 Vaccine** and have made the above indicated decision with respect to receiving the **COVID-19 Vaccine**. If I have elected to not receive the **COVID-19 Vaccine** or to receive the **COVID-19 Vaccine** at another time, I understand the risks associated with this decision and will not hold Provider or Provider's representatives accountable if I contract **COVID-19 disease**.

PATIENT/PARENT SIGNATURE;

_____

Print Name: _____

Relationship to Patient: _____