MemorialCare Medical Foundation

# SARS-COV-2 Vaccine Consent & Administration Form

| PATIENT FIRST NAME | PATIENT LAST NAME |
|---|---|
| DATE OF BIRTH | PHONE NUMBER |
| ADDRESS | |

| SCREENING QUESTIONNAIRE | YES | NO |
|---|---|---|
| Have you ever received a COVID-19 vaccine?<br>If yes, date:________________ Type/Brand of COVID vaccine:_____________________ | | |
| In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due toCOVID-19 infection or exposure? | | |
| Have you received passive antibody therapy as treatment for COVID-19 in the last 90 days? | | |
| Have you ever had a serious reaction (anaphylaxis) to vaccine, injectable medication, food or other? | | |
| Are you sick now with a moderate or severe illness? | | |
| Are pregnant or breast feeding? | | |
| Are you on blood thinners? | | |

**CONSENT**

1. I have been given a copy and have read, or have had explained to me, the information in the FACT SHEET for the COVID-19 vaccine. I understand the FDA has authorized emergency use of the COVID-19 vaccine, which is not an FDA-approved vaccine. I have had the chance to ask questions that were answered to my satisfaction.
2. I have been advised to wait for 15-30 minutes for observation after receiving my vaccine. If I experience a severe reaction while under observation, I understand that 911 will be called.
3. I understand that I am fully responsible for complying with any restrictions prescribed for me by my personal physician. I have discussed the safety of COVID-19 vaccine if I have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system and/or take any medications that affect my immune system.
4. I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
5. I understand the significant known and potential risks and benefits of the COVID-19 vaccine as explained in the FACT SHEET and that some potential risks and benefits may remain unknown.
6. I request that the COVID-19 VACCINE be given to me or to the person listed above, for whom I certify that I am authorized to make this request and consent on their behalf.

_______________________________________________________________________________

**Patient / Patient Agent (Signature)** **Date** **Print Name, if other than Patient**

| Date | Vaccine Name | Administration | Route: IM | Dose | Manufacturer & Lot | Expiration |
|---|---|---|---|---|---|---|
| | ☐ Pfizer<br>☐ Moderna | ☐ First Dose<br>☐ Second Dose | ☐ **R Deltoid**<br>☐ **L Deltoid** | ☐ **0.3ml**<br>☐ **0.5ml** | | |

I have provided the patient (and/or agent or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

**Vaccinator Signature:** ________________________________________________