COVID-19 VACCINATION CONSENT FORM

Last Name (Please print)	First Name	MI	Date of Birth	☐ Male ☐ Female
Address		City	State	Zip
Phone Number	Email		Name of Primary Care Provider	

AGE OF PERSON RECEIVING COVID-19 VACCINE :

SCREENING FOR VACCINATION ELIGIBILITY

Question		
1. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause?	yes	no
2. Have you had a severe allergic reastion (e.g., anaphylaxis , trouble breathing) to any comonent of a COVID -19 vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?	yes	no
3. Have you received convalescnet plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?	yes	no
4. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc?	yes	no
5.. Do you have a bleeding disorder or are you taking a blood thinner?	yes	no
6. Have you tested positive for COVID-19 in the last 10 days?	yes	no
7. Are you currently in qurantine for COVID-19 exposure?	yes	no
8.Have you been diagnosed with Multisystem Inflammatory Syndrome in adults or children in the last 90 days? If you answer yes to this question, it is recommended you consult with your physician prior to receiving the COVID -19 vaccine.	yes	no

9. If this is your second dose, when was the first dose? _____/______/______ What vaccine did you receive? _____________________

10. If this is your Booster when was the first dose? ____/______/______ 2nd dose? ____/_____/_____ What vaccine did you receive? _______________

CONSENT FOR VACCINATION

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adversereactions after leaving, I will notify my care provider. I have viewed the Emergency Use Authorization Fact Sheet provided to me today. I understand the benefits and risks of the vaccine. I understand that I can review a Notice of Privacy Practice at this time of vaccination.

By signing this form, I give permission for a vaccine to be administered to the person above and a record of the vaccination to be entered into the State of Michigan-MCIR care coordination to monitor statewide vaccination coverage. Further, I agree that the information above is correct.

Signature of Parent/Guardian /Patient____Date_________________________________

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Vaccination and EUA Given:	Route IM R L	Manufacturer	Lot No.	Initials of the Administrator
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