SARS-CoV-2 Vaccine (COVID-19)
CONSENT FORM AND ADMINSTRATION RECORD

CLEARLY PRINT information below about the person receiving the vaccine OR CIRCLE correct responses.

Last Name _____ First Name _____ MI _____
Birthdate _____/_____/_____ Sex: _____ F _____ M _____ Other

Ethnicity ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Unknown ___ Unable to report
Race ___ American Indian/Alaska Native ___ Asian ___ Black/African American ___ White
___ Native Hawaiian/Other Pacific Islander __ Other Race/Multi-racial ___Unknown ___ Unable to report

Home Address _____ City _____ State _____ Zip Code _____
County _____ Phone (_____) _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your health care provider to explain it.

1) Are you feeling sick today? ..... ___Yes ___No
2) Have you ever received a dose of COVID-19 vaccine? ..... ___Yes ___ No
   If yes, which vaccine product did you receive: ___Pfizer ___ Moderna ___Janseen (Johnson & Johnson)
3) Have you ever had an allergic reaction to:

(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)

A component of a COVID-19 vaccine including either of the following:

Polyethylene glycol (PEG), found in some medications, such as laxatives & preparations for colonoscopy procedures ___Yes ___No
Polysorbate, found is some vaccines, film coated tablets or intravenous steroids ..... ___Yes ___No
Previous dose of COVID-19 vaccine ..... ___Yes ___No
A vaccine or injectable therapy that contains multiple components, one of which is COVID-19 vaccine component, but is not known which component elicited the immediate reaction ..... ___Yes ___No

4) Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication ___Yes ___No

(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)

5) Have you have had a severe allergic reaction (e.g. anaphylaxis) to something other than a component of COVID-19, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies. ..... ___Yes ___No
6) Have you received any vaccine in the last 14 days? ..... ___Yes ___No
7) Have you ever had a positive test for COVID-19 or has a doctor ever told you that you have had COVID-19?. ___Yes ___No
8) Have you received passive antibody therapy (monoclonal antibodies/convalescent serum) as treatment for COVID-19 ___Yes ___No
9) Do you have a weakened immune system caused by something such as HIV infection, cancer or do you take immunosuppressive drugs or therapies ..... ___Yes ___ No
10) Do you have a bleeding disorder or are you taking a blood thinner? ..... ___Yes ___No
11) Do you have dermal fillers? ..... ___Yes ___ No

Consent

I have received and reviewed FDA Emergency Use Authorization Fact Sheet provided to me. I had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine. I consent to receiving the COVID-19 Vaccine. I acknowledge that this vaccination was approved by the FDA through an emergency use authorization. I hereby release and hold harmless, North Arlington Pediatrics and their employees, from all responsibility for any reaction that may occur from this vaccination. I agree to remain in the post-vaccination observation area for approximately 15 minutes [30 mins for history of servere allergy] after administration for observation by a healthcare provider. I agree to seek medical attention should I experience any severe symptoms, including breathing, dizziness, confusion, sudden weakness, or loss of consciousness.

Signature _____ Date _____

Date administered _____ Vaccine Mfg Pfizer Signature of Vaccine Administrator _____ Route IM R deltoid L deltoid ~~0.5ml~~ 0.3 ml
Printed name _____ (circle)

I-CARE: Initials _____ Date _____