

COVID-19 Vaccine Consent

Name:		Date of Birth:							
Address:			City:		St	ate:	Zip:		
Home Number: Cell Number:									
Gender: ☐ Female ☐ Male Medical Provider:									
Dose #1 Screening									
Are you feeling sick today?						☐ Yes	□ No	☐ Don't Know	
Have you received a COVID-19	•	•				□ Yes	☐ No	☐ Don't Know	
If yes: Date 1 st Dose:									
If yes: Which vaccine?						☐ Yes	<u> </u>		
Have you ever had a severe allergic reaction (anaphylaxis) that required treatment with							□ No	☐ Don't Know	
epinephrine or EpiPen or required hospitalization? Was this sowers allergic reaction after receiving a COVID 19 vassing?						□ v		□ Dan/t Kna	
Was this severe allergic reaction after receiving a COVID-19 vaccine?						□ Yes	□ No	☐ Don't Know	
Was this severe allergic reaction after receiving another vaccine or injectable medication?						□ Yes	□ No	☐ Don't Know	
Have you received antibody therapy (such as convalescent plasma) as treatment for COVID-19? Have you received another vaccine in the last 14 days?						□ Yes	□ No	☐ Don't Know	
Have you tested positive for CO		t 14 uays:				☐ Yes	□ No	☐ Don't Know	
If yes: Date	OAID-18.					□ Yes	☐ No	☐ Don't Know	
Do you have a weakened immune system (such as HIV or cancer) or do you take immuno-suppressive drugs or therapies?					nmuno-	☐ Yes	□ No	☐ Don't Know	
Do you have a bleeding disorder or are you taking a blood thinner?						☐ Yes	□ No	☐ Don't Know	
Are you pregnant or breastfeeding?						□ Yes	□ No	☐ Don't Know	
 The FDA has authorized the emergency use of the Moderna COVID-19 Vaccine that may prevent COVID-19. This vaccine is not FDA-approved. There is no FDA-approved vaccine to prevent COVID-19. The FDA has authorized the emergency use of this vaccine for individuals age 18 and older. V-safe is a smart-phone based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after receiving the vaccine. I understand that participation with V-safe is voluntary and that I must enroll myself. This vaccine is a 2-dose series and I must receive both doses in order to achieve the best immunity. I need to make sure that I receive that second dose as close to 28 days after my first dose as possible. 									
Vaccination Release I have read or have had explained to me the information on the Emergency Use Authorization (EUA) Fact Sheet or Vaccine									
I have read or have had ex Information Statement (VIS). be given to me or to the posupervisors, Crawford Coun responsible for any reaction Printed name:	. I have had a derson for who nety Board of I or adverse eff	chance to ask q om I am autho Health, or Crav ects of this vac	uestions that worized to make wford County Ficine.	ere answered this request. Home Health,	to my sati I will not Hospice {	sfaction hold Cr & Public	. I consen awford Co	t to the vaccine ounty Board of agency or staff	
Printed name: Date:									
Date: Dose #1 Manufacturer	Lot #	Exp Date	VIS/EUA Date	Dose	Site		m By	IRIS date/initial	
Moderna	0111204	5-11-2021	12/20/2020	0.5 ml	R L Del		,	auto, mitiai	



COVID-19 Vaccine Consent

Dose #2 Screening								
Has any of your contact information on page 1 changed?	☐ Don't Know							
Are you feeling sick today?	☐ Don't Know							
Have you received a COVID-19 vaccine previously? ☐ Yes ☐ No	☐ Don't Know							
If yes: Date 1 st Dose:Date 2 nd Dose:								
If yes: Which vaccine? Pfizer Moderna Other:								
Have you ever had a severe allergic reaction (anaphylaxis) that required treatment with \square Yes \square No	☐ Don't Know							
epinephrine or EpiPen or required hospitalization?								
Was this severe allergic reaction after receiving a COVID-19 vaccine? ☐ Yes ☐ No	☐ Don't Know							
Was this severe allergic reaction after receiving another vaccine or injectable medication?	☐ Don't Know							
Have you received antibody therapy (such as convalescent plasma) as treatment for COVID-19?	☐ Don't Know							
Have you received another vaccine in the last 14 days? ☐ Yes ☐ No	☐ Don't Know							
Have you tested positive for COVID-19? ☐ Yes ☐ No	☐ Don't Know							
If yes: Date								
Do you have a weakened immune system (such as HIV or cancer) or do you take immuno-	☐ Don't Know							
suppressive drugs or therapies?								
Do you have a bleeding disorder or are you taking a blood thinner?	☐ Don't Know							
Are you pregnant or breastfeeding?	☐ Don't Know							
By signing the consent, I acknowledge that I understand the following:								
 The FDA has authorized the emergency use of the Moderna COVID-19 Vaccine that may prevent COVID-19. This vaccine 								
is not FDA-approved. There is no FDA-approved vaccine to prevent COVID-19. The FDA has authorized the emergency use								
of this vaccine for individuals age 18 and older.								
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vaccinated to identify potential side effects after receiving the vaccine. I understand that participation with V-safe is								
voluntary and that I must enroll myself.								
This vaccine is a 2-dose series and I must receive both doses in order to achieve the best immunity. I need to make sure								
that I receive that second dose as close to 28 days after my first dose as possible.								
Vaccination Release								
I have read or have had explained to me the information on the Emergency Use Authorization (EUA) Fact Sheet or Vaccine								
Information Statement (VIS). I have had a chance to ask questions that were answered to my satisfaction. I consent to the vaccine								
be given to me or to the person for whom I am authorized to make this request. I will not hold Crawford County Board of								
Supervisors, Crawford County Board of Health, or Crawford County Home Health, Hospice & Public Health agency or staff								
responsible for any reaction or adverse effects of this vaccine.								
responsible for any reaction of daverse effects of this vaccine.								

Printed name: ______ Date: ______ Date: _____