**CONSENT FOR COVID-19 VACCINE**

**Please complete the following**

Patient Name: Date of Birth:

Address: City/State/Zip

Phone:

Do you have any allergies:  No  Yes (complete the following)

Allergy: Reaction:

Allergy: Reaction:

Allergy: Reaction:

The vaccine for COVID-19 (SARS-CoV2) has been authorized under an Emergency Use Authorization by the FDA because of the ongoing pandemic and the need to reduce severe illness and death from this virus.

**Your initial to the below statements verifies understanding.**

\_\_\_\_\_\_ I have had the opportunity to read and ask questions about the COVID-19 VIS/EUA Fact Sheet. My questions were answered to my satisfaction.

\_\_\_\_\_\_ I believe I understand the benefits and risks of the vaccine and asked that the vaccine will be given to me or the person named above as I am authorized to make this request.

\_\_\_\_\_\_ I understand this is a 2-dose series (staff to circle dose return date: 21 or 28 days apart) and it is not fully effective unless I receive both doses within the recommended time frame.

\_\_\_\_\_\_ I am over the age of 18 and NOT pregnant as we do not know the effects of the vaccine on pregnancy

\_\_\_\_\_\_ I understand, even though I am receiving this vaccine, I can still acquire and spread COVID -19 even without symptoms and I need to follow CDC guidelines on social distancing, wearing a face covering, hand hygiene and disinfection measures.

\_\_\_\_\_\_ I understand getting vaccinated does not guarantee immunity to COVID-19.

\_\_\_\_\_\_ I received my COVID-19 Vaccine Record Card with information on approximate return date for the second vaccination, product name and lot number I also received V-safe handout.

1st Dose Signature: Date:

1st Dose Staff Signature: Co-signer:

Vaccine Manufacturer: Lot #: Injection Site:

**Before receiving my 2nd Vaccination I have reviewed the above information and have reported any significant adverse reactions to the first COVID-19 Vaccination.**

If you experienced a reaction, please describe:

2nd Dose Signature: Date:

2nd Dose Staff Signature: Co-signer:

\*By signing for second dose I verify that the above section regarding a significant adverse reaction has been reviewed and reported before administration if indicated.

Vaccine Manufacturer: Lot #: Injection Site: