Family Health Care

Accredited by the ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

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: ______________________

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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: ______________