Consent to Administer COVID-19 Vaccination

Patient Name: _____
DOB: _____/_____/_____ **Age**: _____
Street Address: _____ **Town/City**: _____
County:_____ **State**: _____ **Zip**: _____

Gender (please circle): ☐ Female ☐ Male ☐ Other ☐ Decline to Specify

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Unknown ☐ Decline to Specify

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown ☐ Decline to Specify

SCREENING QUESTIONS	Yes	No	Don't Know
Are you feeling sick today?			
Have you ever received a dose of a COVID-19 vaccine before? **If yes,** which COVID-19 vaccine product(s) were you previously given? (please circle) Pfizer-BioNTech Moderna Janssen (Johnson & Johnson)			
Did you have an allergic reaction after a prior dose of COVID-19 vaccine? *Allergic reactions can include symptoms like rash, hives, swelling of face or mouth, wheezing and difficulty breathing, etc. – Please specify: __*			
Do you have a known allergy to an ingredient in the Pfizer-BioNTech COVID-19 vaccine? *See the provided age-appropriate FDA Fact Sheet for a list of vaccine ingredients.*			
Do you have a known allergy to polyethylene glycol (PEG)?			
Do you have a known allergy to polysorbate?			
Have you ever had any allergic reaction within 4 hours of receiving a non-COVID-19 vaccine or other injectable medication (including medications injected into a muscle, vein, or under the skin)?			
Have you ever had a severe allergic reaction (like anaphylaxis due to any other cause, including to medications taken by mouth, food, or other substances?			
Did you develop myocarditis or pericarditis after receiving a prior dose of either the Pfizer-BioNTech or Moderna COVID-19 vaccine?			
Do you have a bleeding disorder or are you taking blood thinners?			
In the last 90 days, have you been given a COVID-19 antibody therapy to either treat COVID-19, or to prevent COVID-19 from developing after you were exposed to another person with COVID-19? *(Antibody therapies include monoclonal antibodies or a blood product called "convalescent plasma")*			

In the last 90 days, did you develop an immune-related health condition that caused blood clotting AND low platelet blood counts? (T*he most common example of this is called "heparin-induced thrombocytopenia"*)			
Did you develop a health condition called "thrombosis with thrombocytopenia" (TTS) after receiving a prior dose of the Janssen vaccine? (*People with this syndrome develop blood clotting and low platelet blood counts after receiving the Janssen vaccine*)			
Did you develop Guillain-Barré syndrome (GBS) after receiving a prior dose of the Janssen vaccine?			

Consent**:**

I hereby acknowledge the following: (please initial)

_____ I have completed the appropriate health screening questionnaire prior to vaccination and have no known contraindications to this vaccination.

_____ I have been provided with a copy of, and reviewed the contents of, the age-appropriate FDA Fact Sheet for people receiving the COVID-19 vaccine or Moderna vaccine.

_____ I acknowledge that I have received and reviewed the information provided and I confirm that the information entered on this form is accurate to the best of my knowledge.

_____ I acknowledge that I am required to wait a minimum of 15 minutes after administration of the vaccination before leaving the vaccination site.

I understand, as a condition of receiving the COVID-19 vaccine today, my personal health information, or that of my child/ward, may be shared as allowable under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (see DHHS Notice of Privacy Practices).

I understand unless I have **SIGNED THE SEPARATE** *Choose not to Participate in the NH Immunization/Vaccination Registry* form exercising my right to opt out under NH RSA 141-C:20-f, and NH Administrative Rule He-P 307.06, and have checked the box below, my immunization information will also be entered into the NH Immunization/Vaccination Registry.

☐ I choose **NOT** to participate in the NH Immunization/Vaccine Registry (MUST COMPLETE SEPARATE FORM)

I consent to the administration of the Vaccine by the Regional Public Health Department. I fully release and discharge Regional Public Health Department, its affiliates and their officers, directors, employees and persons acting on their behalf or at their direction from any liability or claim related to the administration of, or receipt of, the Vaccine.

Signature of Vaccine Recipient: _____ Date: _____

Printed Name of Vaccine Recipient: _____

Phone Number: _____

Email Address: _____

Vaccine:_____ VIS/EUA Date: _____ Lot #: _____

Exp Date:_____ Dose amount: _____ Site: _____ Date Admin: _____

Time Given: _____ Admin by: _____

Clinic Name: _____