COVID-19 Vaccine Consent

PLEASE PRINT

Patient Last Name:	**First Name:**	**MI:**
Sex: ☐ M ☐ F	**DOB:** / /	**Age:**
Race: ❑Asian ❑Black ❑Native American ❑Pacific Islander ❑White ❑Other:	**Ethnicity:** Hispanic ❑Yes ❑No	
Primary Language:	**Email Address:**	
Address:	**City:** **State:**	**Zip:**
Cell Phone: ( )	**Alternate Phone:** ( )	
Company/Job Location:	**Job Title:**	

The following questions will help determine if there is any reason you should not receive a COVID immunization injection.

Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.

1.	Has the person to be vaccinated ever received a COVID-19 vaccine? Date: _____ Manufacturer: _____	☐ Yes ☐ No
2.	Does the person to be vaccinated have an allergy to a component of the vaccine? Allergies: _____	☐ Yes ☐ No
3.	Has the person to be vaccinated ever had a severe (anaphylaxis) reaction to an injectable or intravenous medication or vaccine? **[Defer to POD Supervisor]**	☐ Yes ☐ No
4.	Has the person to be vaccinated ever had a severe (anaphylaxis) reaction due to any cause? **[Defer to POD Supervisor]**	☐ Yes ☐ No
5.	Is the person to be vaccinated sick today, including symptomatic or asymptomatic infection with COVID-19?	☐ Yes ☐ No
6.	Has the person to be vaccinated received any vaccine in the past 14 days?	☐ Yes ☐ No
7.	Has the person to be vaccinated received passive antibody therapy for COVID-19 in the past 90 days?	☐ Yes ☐ No
8.	Is the person to be vaccinated younger than 16 years old (Pfizer vaccine) or 18 years old (Moderna vaccine)?	☐ Yes ☐ No
9.	Is the person to be vaccinated pregnant or breastfeeding?	☐ Yes ☐ No
10.	Will you be available 3 weeks (Pfizer vaccine) or 4 weeks (Moderna vaccine) from today to receive your necessary second dose of the vaccine?	☐ Yes ☐ No

Request for Administration of COVID-19 Vaccine for the above-named recipient: I acknowledge that I have received the Vaccine Information Statement or Emergency Use Authorization Information Sheet. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I am aware that, to provide protection against the virus that causes COVID-19, two doses of this same vaccine may be required. I acknowledge that I may receive a reminder for a second dose by email, phone call, text (if cell phone number provided, standard messaging rates may apply), or mail.

I hereby release Metro Public Health Department of Nashville & Davidson County, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

PATIENT/PARENT OR GUARDIAN/POWER OF ATTORNEY SIGNATURE: _____ **DATE:** _____

This consent is valid for 12 months from date signed.

12.22.2020 eam

COVID-19 Vaccine Consent

Vaccination Site Location: ☐ **CORE Clinic – 217 South 10th Street, Nashville, TN, 37206**

☐ **HCA Clinic – Building 4, 2555 Park Plaza, Nashville, TN 37203**

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Immunization **[INJECTION #1]** Documentation

Manufacturer:

Dose: ☐0.3mL (Pfizer) **Route:** IM
☐ 0.5ml (Moderna)

Site Administered: ☐Right Deltoid ☐Left Deltoid ☐[Other]

Lot Number: _____ **Expiration Date:** / / **EUA Date:** Pfizer: 12/2020
Moderna: 12/2020

Date Given: / /

Signature: _____
***Provider signature indicates immunization given according to PHN protocol.*

☐Vaccine NOT given secondary to contraindication:

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Immunization **[INJECTION #2]** Documentation

☐All initial screening questions have been reviewed and discussed

Manufacturer:

Dose: ☐ 0.3mL (Pfizer) **Route:** IM
☐ 0.5ml (Moderna)

Site Administered: ☐Right Deltoid ☐Left Deltoid ☐[Other]

Lot Number: _____ **Expiration Date:** / / **EUA Date:** Pfizer: 12/2020
Moderna: 12/2020

Date Given: / /

Signature: _____
***Provider signature indicates immunization given according to PHN protocol.*

☐Vaccine NOT given secondary to contraindication: