COVID-19 Vaccine Consent

PLEASE PRINT

Patient *FIRST* Name: **_LAST_ Name**: **MI**:

Maiden Name (Optional):

DOB: / / **Current Age**: **Sex**: ☐ F ☐ M ☐ Other

Race: ☐White ☐Black or African American ☐Asian ☐American Indian or Alaskan Native ☐Other ☐Native Hawaiian or Other Pacific Islander ☐Unknown

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Unknown

Address: **City**: **State**: **Zip**:

Cell Phone: ( ) **Alternate Phone:** ( )

The following questions will help determine if there is any reason you should not receive a COVID immunization injection. Questions should be answered for the person who will be vaccinated.
If a question is not clear, please ask a healthcare provider to explain.

1. Younger than 12 yearsold?.. ☐ Yes ☐ No
2. History of any immediate allergic reaction, of any severity, after a previous dose of mRNA COVID-19 vaccine or any of its components (including polyethylene glycol [PEG]) or polysorbate?.. ☐ Yes ☐ No
   Cause/Allergy: ____________________
3. History of immediate allergic reaction of any severity to any substance?.............................. ☐ Yes ☐ No
   Cause/Allergy: ____________________
4. Ever received a COVID-19 vaccine?... ☐ Yes ☐ No
   1st Dose Date:____________Manufacturer:____________
   2nd Dose Date:____________Manufacturer:____________
5. Sick today, including symptomatic/asymptomatic infection with COVID-19?......................... ☐ Yes ☐ No
6. Received passive antibody therapy for COVID-19 in the last 90 days?.................................. ☐ Yes ☐ No
7. Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-)?.............................. ☐ Yes ☐ No
8. Pregnantorbreastfeeding?.. ☐ 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 and the Tennessee Department of Health's Notice of Privacy Practices. 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, additional doses may be required. I acknowledge that I may receive a reminder for additional doses by text (if cell phone number provided, standard messaging rates may apply), phone call, or mail.

PATIENT/PARENT OR GUARDIAN/POWER OF ATTORNEY SIGNATURE:____________________DATE: __________

This consent is valid for 12 months from date signed.

Site Location: ☐ **Alumni Hall** ☐ **Other:** ____________________________

AREA FOR OFFICIAL USE ONLY
Nursing Immunization **(INJECTION #1)** Documentation

Manufacturer: ☐Pfizer ☐Moderna ☐J&J (Janssen)
Dose: ☐0.3 mL ☐ 0.5 mL ☐_______ mL **Route**: IM

Site Administered: ☐Right Deltoid ☐Left Deltoid ☐___________

Lot Number:_________________ **Expiration Date:** / /

Date Given: / /

Signature: ___________________________________
Signature indicates immunization given according to PHN Protocol

☐ All initial screening questions have been reviewed and discussed.
☐ Vaccine NOT given secondary to contraindication:

AREA FOR OFFICIAL USE ONLY
Nursing Immunization **(INJECTION #2)** Documentation

Manufacturer: ☐Pfizer ☐Moderna ☐J&J (Janssen)
Dose: ☐0.3 mL ☐ 0.5 mL ☐_______ mL **Route**: IM

Site Administered: ☐Right Deltoid ☐Left Deltoid ☐___________

Lot Number:_________________ **Expiration Date:** / /

Date Given: / /

Signature: ___________________________________
Signature indicates immunization given according to PHN Protocol

☐ All initial screening questions have been reviewed and discussed.
☐ Vaccine NOT given secondary to contraindication:

AREA FOR OFFICIAL USE ONLY
Nursing Immunization **(INJECTION #3)** Documentation
FOR IMMUNOCOMPROMISED INDIVIDUALS

Manufacturer: ☐Pfizer ☐Moderna ☐J&J (Janssen)
Dose: ☐0.3 mL ☐ 0.5 mL ☐_______ mL **Route**: IM

Site Administered: ☐Right Deltoid ☐Left Deltoid ☐___________

Lot Number:_________________ **Expiration Date:** / /

Date Given: / /

Signature: ___________________________________
Signature indicates immunization given according to PHN Protocol

☐ All initial screening questions have been reviewed and discussed.
☐ Vaccine NOT given secondary to contraindication: