COVID Vaccine Consent Form

Section 1: Information about Patient to Receive Vaccine (please print) **DL or SS#________________________________**

NAME (Last)		(First)	(M.I.)	**DATE OF BIRTH** **month________day________ year _______**	
PARENT/LEGAL GUARDIAN'S NAME (Last) if applicable:		(First)	(M.I.)	**AGE**	**GENDER** **_____M _____ F**
ADDRESS				**Race: ____________Ethnicity:_____________** **PATIENT/GUARDIAN PHONE NUMBER:**	
CITY	**STATE**	**ZIP**			

Section 2: Screening for Vaccine Eligibility

	YES	NO
1. Are you sick today?		
2. Have you had a severe reaction to a previous dose of this vaccine or to any ingredients in this vaccine?		
3. Do you carry an Epi-pen for emergency treatment of anaphylaxis?		
4. For women, are you pregnant or is there a chance you could become pregnant?		
5. For women, are you breastfeeding?		
6. Have you had any other vaccines in the last 14 days?		
7. In the past 2 weeks, have you tested positive for COVID-19?		
8. Have you had in the last 10 days fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, congestion or runny nose, nausea, vomiting, or diarrhea?		

Section 3: Immunization Screening Guidance For COVID-19 Vaccine

	YES	NO
9. Do you have allergies or reactions to any medications, foods, vaccines, or latex? Please explain:		
10. Are you immunocompromised or on a medicine that affects your immune system?		
11. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?		
12. Have you received a previous dose of any COVID-19 vaccine? If yes, which manufacturer's		

Section 4: Acknowledging Fact Sheet

________ (Initials) I have been provided and have had a chance to read or have been read the most up to date Vaccine Fact Sheet for the COVID vaccine and have had the chance to ask questions and understand the risks and benefits.

Section 5: CONSENT:

________ (Initials) **I GIVE CONSENT** to Central Florida Health Care, Inc. and its staff for me or the person I am the guardian for, to be vaccinated with this vaccine.

- I understand my insurance will be billed for the administration of the vaccine and will need to provide my social security or driver's license number.
- I understand I will not receive a bill for the vaccine.

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- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Central Florida Health Care, Inc (CFHC), and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
- I acknowledge that: (a) I understand the purposes/benefits of Florida SHOTS, Florida's immunization registry and (b) CFHC will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I acknowledge receipt of the Notice of Privacy Rights.

Signature of Patient/Legal Guardian: ____

Date Consent for Vaccine Given: ____/____/____

***CLINICAL SECTION*:**

Section 6: I have reviewed the above information with the patient: ____________________________________
Printed name of Clinical Staff Member

Section 7: Vaccination Record (Must be completed, even if documented in EMR)

Route & Site	Dose	Date Dose Administered	Vaccine Manufacturer	Lot Number and Expiration Date	Date of EAU Fact Sheet
IM _____RD _____LD	_______ 1st _______2nd	**05-03-2021**	X Moderna ___ Pfizer	**014C21A** **10-16-2021**	**12/2020**

Clinical Staff Print Name: ____

Signature:____________________________________ **Date:** _______________

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