COVID-19 Vaccination Consent Form 2021

PURPLESHIELD MEDICAL
www.purpleshieldmedical.com

Last Name *(Please print)*	First Name	MI	Date of Birth	☐ Male ☐ Female

Address	City/State	ZIP	Ethnicity

Phone Number	Email	Name of Primary Care Provider

SCREENING FOR VACCINATION ELIGIBILITY

Question		
1. Are you pregnant?	Yes	No
2. Are you currently breastfeeding?	Yes	No
3. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any vaccine orinjectable therapy, or a history of anaphylaxis due to any cause?	Yes	No
4. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of aCOVID-19 vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?	Yes	No
5. Have you received any other vaccine within the past 14 days or are scheduled to receive any vaccine inthe next 14 days?	Yes	No
6. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19within the past 90 days?	Yes	No
7. Are you under age 16?	Yes	No
8. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness ofbreath, difficulty breathing, fatigue, muscle or body aches, etc.?	Yes	No
9. Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No
10. Have you tested positive for COVID-19 in the last 10 days?	Yes	No
11. Are you currently in quarantine for COVID-19 exposure?	Yes	No
12. If this is your second dose, when was the date of your first dose?	/ /	
13. If this is your second dose, which vaccine did you receive (Pfizer, Moderna, etc.)?		

CONSENT FOR VACCINATION

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization Fact Sheet provided to me today. I understand the benefits and risks of the vaccine.

The vaccine checked above should be given to the person named above for whom I am authorized to make this request. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

Signature of Parent/Guardian/Patient____Date__________

FOR ADMINISTRATIVE USE ONLY **VIS Date:**

Vaccine	**Date Vaccination and EUA Given:**	**Left or Right Arm**	**Lot No.**	**Printed Name and Signature of Vaccine Administrator**
				Print Name
				Signature

Patient Number #
Time Slot:

INFORMATION FOR HEALTH CARE PROFESSIONALS ABOUT VACCINATION ELIGIBILITY

1. Are you pregnant?

   IF YES: Please ask the patient whether they discussed vaccination with a medical provider. Patients who are pregnant may choose to be vaccinated whether they discussed vaccination with a medical provider or not.

2. Are you currently breastfeeding?

   IF YES: Please ask the patient whether they discussed vaccination with a medical provider. Patients who are lactating may choose to be vaccinated whether they discussed vaccination with a medical provider or not.

3. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to a vaccine or injectable therapy, or a history of anaphylaxis due to any cause?

   IF YES: Please ask the patient whether they discussed vaccination with a medical provider. If they have, allow vaccination to proceed. Vaccine providers should observe patients after vaccination to monitor for the occurrence of immediate adverse reactions:
   - **Persons with a history of anaphylaxis: 30 minutes**
   - **All other persons: 15 minutes**

4. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of the vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?

   IF YES: Do Not Vaccinate

5. Have you received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next 14 days?

   IF YES: Do Not Vaccinate

6. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?

   IF YES: Do Not Vaccinate

7. Are you under age 16?

   FOR PFIZER VACCINE, IF YES: Do Not Vaccinate

   FOR MODERNA VACCINE, IF UNDER AGE 18: Do Not Vaccinate

8. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?

   IF YES: Have patient discuss existing symptoms with a medical provider.

9. Do you have a bleeding disorder or are you taking a blood thinner?

   IF YES: Have patient discuss with a medical provider. ACIP recommends the following technique for intramuscular vaccination in patients with bleeding disorders or taking blood thinners: a fine-gauge needle (23-gauge or smaller caliber) should be used for the vaccination, followed by firm pressure on the site, without rubbing, for at least 2 minutes.

10. Have you tested positive for COVID-19 in the last 10 days?

    IF YES: Do Not Vaccinate

11. Are you currently in quarantine for COVID-19 exposure?

    IF YES: Do Not Vaccinate

12. If this is your second dose, when was the date of your first dose?

    Do Not Vaccinate if less than 17 days ago for Pfizer, or less than 24 days ago for Moderna.

13. If this is your second dose, which vaccine did you receive (Pfizer, Moderna, etc.)?

    Ensure that the second dose is from the same manufacturer as the first dose.
    If different: Do Not Vaccinate.