COVID-19 Vaccine Informed Consent Form (all fields required)

First Name:_________________________ Last Name: ________________________________M.I:______ Gender: M ☐ F ☐

DOB:_________________ Age:________ Mother's Maiden Name: ____

Phone:____ Email:____

Street Address:____________________________City:________________________State: _______ Zip code: __________

Hispanic/Latino?: Y ☐ N ☐ **Race:** White ☐ Asian ☐ Black ☐ Pacific Islander☐ Native American ☐ Other ☐

1. Are you feeling sick today? ....Y ☐ N ☐

2. Have you ever received a dose of COVID-19 vaccine?...Y ☐ N ☐

- If yes, which vaccine product did you receive?
  ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product _________________
- How many doses of COVID-19 vaccine have you received? _________________

3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? ....Y ☐ N ☐

- This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.

4. Have you received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies? ..Y ☐ N ☐

5. *Have you had an allergic reaction to:

- A component of a COVID-19 vaccine ....Y ☐ N ☐
- A previous dose of COVID-19 vaccine ....Y ☐ N ☐

6. *Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? ....Y ☐ N ☐

7. Check all that apply to you:

☐ Have a history of myocarditis or pericarditis
☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)
☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia
☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
☐ Have a history of Guillain-Barré Syndrome (GBS)
☐ Have a history of COVID-19 disease within the past 3 months
☐ None of the above

*For questions 5 and 6: allergic reaction would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.

Consent for Treatment and Privacy Notice

I certify that the information I have provided is true and accurate. I have had a chance to review the Covid-19 vaccine Information (EUA Fact Sheet) and consent to receive the vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine. I understand and agree that information related to my vaccine administration may be recorded in the Utah Statewide Immunization Information System (USIIS). I hereby release Southwest Utah Public Health Department (SWUPHD), and its employees, from all claims arising from such immunizations. We are required to inform you of our privacy practices for the information we collect and keep about you. I have been given a copy of the Health Department's Notice of Privacy Practices and have had an opportunity to ask questions about how my information may be used.

Signature:__________________________________ Print Name: ____________________________________ Date: ____________

Relationship to Client: Self ☐ Parent ☐ Legal Guardian ☐ Other ☐ _________________________________

Local Health Department Use

Date	Mfr	Lot #	Exp.	Dose in mL	Rte	Site	Vaccinator
				0.2 0.25 0.3 0.5	IM	LD RD LVL RVL	

Form Version: 7.18.22