Geauga County Health District- COVID-19 Pfizer Vaccine Consent Form 2020-2021

LAST NAME	FIRST NAME	MIDDLE INT.	DOB	AGE
			/ /	

ADDRESS	CITY	STATE

ZIP	COUNTY	PHONE

SEX	RACE	ETHNICITY
☐ Female ☐ Other ☐ Male ☐ Unknown	☐ Alaskan Native ☐ Pacific Islander ☐ American Indian ☐ Native Hawaiian ☐ Asian ☐ White ☐ Black ☐ Other ☐ Unknown	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

Please answer the following questions for Immunizer to review:	Yes	No
1. Are you feeling sick today? Documented temperature by Immunizer: _____		
2. Have you ever received a dose of COVID-19 vaccine?		
If yes, which vaccine product? ☐ Pfizer, ☐ Moderna, ☐ Another product_____		
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?		
• Was the severe allergic reaction after receiving a COVID-19 vaccine?		
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?		
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?		
5. Have you received <u>any</u> other vaccines in the last 14 days?		
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		
• Did the test or diagnosis take place in the past 3 months?		
7. Do you have a weakened immune system caused by something such as HIV infection or cancer, or do you take immunosuppressive drugs or therapy?		
8. Do you have a bleeding disorder or are you taking a blood thinner?		
9. Are you pregnant or breastfeeding?		

<u>Patient's Consent:</u> By my signature below, I affirm that the information provided on this form is accurate and complete to the best of my knowledge. I give permission for myself to receive the EUA COVID-19 Vaccine. I understand that after the vaccination is given, I have been advised to wait on-site for 15 minutes (30 minutes for persons with a history of severe allergy to an injectable medication) under the supervision of an RN. I was given the opportunity to ask questions about the EUA COVID-19 Vaccine. I understand that it is not possible to predict all side effects or complications. I release and hold harmless all Geauga Public Health providers and employees from any and all liability or claims related to the vaccine listed above. A copy of the Federal Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers was available for review along with information about enrollment in the V-safe program. I understand that all immunizations provided are documented in the State of Ohio Immunization Registry. **<u>I understand that I must be at least 16 years old in order to receive this vaccine. If I am under 18, I understand that I may be asked for my ID to confirm my age, and that my consent form must have my parent/guardian's name and signature.</u>** I understand that this agreement will remain in effect for the duration of time that GPH is able to provide the COVID-19 Vaccine to myself. I have read and fully understand the benefits and risks of this COVID-19 Vaccine and ask that the vaccine indicated in this sheet be given to myself by the Geauga Public Health District.

Parent/Guardian Name

<u>Parent/Guardian Signature</u>	<u>Date</u>
X_____	X_____/_____/_____
<u>Patient</u>	<u>Date</u>
X_____	X_____/_____/_____

For Geauga Public Health Department Use Only	
Vaccine Manufacturer:	
Vaccine Lot Number:	
Dose in Series:	☐ First ☐ Second
Route/Site of Administration	IM Deltoid Right Left

Comments

Signature of Vaccine Administrator **Date of Administration**