Vernon Memorial Healthcare
So much care, so close.

Patient sticker here

CONSENT FORM FOR THE COVID-19 VACCINE

Last Name (Please Print)	First Name	MI	Date of Birth	Male Female
Address	City		State	Zip
Phone Number	Email		Name of Primary Care Provider	

Screening For Vaccine Eligibility		
Are you 18 years or older?	Yes	No
Have you experienced an anaphylactic or other severe allergic reaction to any injectable medication in the past?	Yes	No
Are you currently recovering from COVID-19 or did you knowingly experience an unprotected exposure to someone with COVID-19 in the past 14 days, including household contacts or community exposures?	Yes	No
If yes to the question above: are you allergic to polyethylene glycol (PEG) or polysorbate (components in some medications including laxatives and bowel preps for colonoscopy procedures)?	Yes	No
If yes to the question above: was it to a previous dose of this vaccine?	Yes	No
Have you received any immunizations in the past 14 days?	Yes	No
Have received any treatment for COVID-19 in the past 90 days?	Yes	No
If yes, was this treatment convalescent plasma therapy or a monoclonal antibody such as bamlanivimab (BAM), casirivimab or imdevimab?		
Have you experienced problems with bleeding from previous injections?	Yes	No
If you are immunocompromised or on immunosuppressant therapy, have you considered the possibility of not getting full effectiveness from the vaccine?	Yes	No
If you are you pregnant or breastfeeding, have you considered the risk of becoming infected with COVID 19 versus lack of safety data for this vaccine?	Yes	No
Are you an employee or volunteer at this clinic or hospital?	Yes	No

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 Patient/Patient's Legal Representative _____

Date_____