COVID-19 VACCINE CONSENT

INFORMATION ABOUT THE PERSON TO RECEIVE THE VACCINE

Name: Last, First, MI	Date of Birth
Home Address	Employee ID
City, State, ZIP	Telephone Number

	YES	NO
Do you have a fever (temperature > 100.4°), or are you sick today (anything more than a "cold")?	☐	☐
Have you ever had a severe allergic reaction?	☐	☐
Are you pregnant or lactating, or do you plan to become pregnant in the next month?	☐	☐
Do you have shortness of breath, dry cough, runny nose, sore throat, muscle pain, or loss of taste or smell?	☐	☐
Have you recently been in close contact with anyone with confirmed or suspected COVID-19 infection?	☐	☐
Have you recently traveled outside the U.S., or within the U.S. by commercial airline, bus or train?	☐	☐
Are you taking any antiviral medication?	☐	☐
Have you received any other vaccinations in the past four weeks?	☐	☐
Do you have a long-term health problem such as heart disease, lung disease, kidney disease, metabolic disease such as diabetes, asthma, neurologic or neuromuscular disease, or anemia or another blood disorder?	☐	☐
Do you have a weakened immune system because of HIV/AIDS or any other disease that attacks the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	☐	☐
Do you live with, or expect to have contact with, a person whose immune system is severely compromised and must be in protective isolation?	☐	☐

I appreciate that it is not possible to consider every possible complication to vaccination.
I have had an opportunity to ask questions about this vaccination.
I believe I understand this information, and my questions have been answered to my satisfaction.
I understand the benefits and risks of the COVID-19 vaccine and request the vaccine be given to me.

☐ **I CONSENT to informing my Employer and the State Immunization Registry that I have received the COVID-19 vaccine.**