COVID-19 Vaccine Consent

PLEASE PRINT

Patient Last Name:	**First Name**:	**MI**:
Sex: ☐ M ☐ F	**DOB**: / /	**Age**:
Race:❑Asian ❑Black ❑Native American ❑Pacific Islander ❑White ❑Other:	**Ethnicity:** Hispanic ❑Yes ❑No	
Primary Language:	**Email Address:**	
Address:	**City**: **State**:	**Zip**:
Cell Phone: ( )	**Alternate Phone:** ( )	
Company/Job Location:	**Job Title:**	

The following questions will help determine if there is any reason you should not receive a COVID immunization injection. *Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.*		
1.	Has the person to be vaccinated ever received a COVID-19 vaccine? Date: ______________ Manufacturer: ___________________________	☐ Yes ☐ No
2.	Does the person to be vaccinated have an allergy to a component of the vaccine? Allergies:____	☐ Yes ☐ No
3.	Has the person to be vaccinated ever had a severe (anaphylaxis) reaction to an injectable or intravenous medication or vaccine? **[Defer to POD Supervisor]**	☐ Yes ☐ No
4.	Has the person to be vaccinated ever had a severe (anaphylaxis) reaction due to any cause? **[Defer to POD Supervisor]**	☐ Yes ☐ No
5.	Is the person to be vaccinated sick today, including symptomatic or asymptomatic infection with COVID-19?	☐ Yes ☐ No
6.	Has the person to be vaccinated received any vaccine in the past 14 days?	☐ Yes ☐ No
7.	Has the person to be vaccinated received passive antibody therapy for COVID-19 in the past 90 days?	☐ Yes ☐ No
8.	Is the person to be vaccinated younger than 16 years old (Pfizer vaccine) or 18 years old (Moderna vaccine, Johnson & Johnson Vaccine)?	☐ Yes ☐ No
9.	Is the person to be vaccinated pregnant or breastfeeding?	☐ Yes ☐ No
10.	Will you be available 3 weeks (Pfizer vaccine) or 4 weeks (Moderna vaccine) from today to receive your necessary second dose of the vaccine?	☐ Yes ☐ No

Request for Administration of COVID-19 Vaccine for the above-named recipient: I acknowledge that I have received the Vaccine Information Statement or Emergency Use Authorization Information Sheet. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I am aware that, to provide protection against the virus that causes COVID-19, two doses of this same vaccine may be required. I acknowledge that I may receive a reminder for a second dose by email, phone call, text (if cell phone number provided, standard messaging rates may apply), or mail.

I hereby release Meharry Medical Group and Meharry Medical College, their affiliates, employees, volunteers, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

PATIENT/PARENT OR GUARDIAN/POWER OF ATTORNEY SIGNATURE: ______________________________ DATE: __________

This consent is valid for 12 months from date signed.

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Vaccination Site Location: ☐ **Meharry Medical Group, 1005 D.B. Todd Blvd, Nashville, TN, 37208**

☐ **Meharry Pediatric Clinic, 1005 D.B. Todd Blvd, Nashville, TN 37208**

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Immunization **[INJECTION #1]** Documentation

Manufacturer:

Dose: ☐0.3mL (Pfizer) **Route**: IM
☐ 0.5ml (Moderna)

Site Administered: ☐Right Deltoid ☐Left Deltoid ☐[Other]

Lot Number: _________________ **Expiration Date:** / / **EUA Date:** Pfizer: 12/2020
Moderna: 12/2020

Date Given: / /

Signature: ___________________________________
***Provider signature indicates immunization given according to PHN protocol.*

❑Vaccine NOT given secondary to contraindication:

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Immunization **[INJECTION #2]** Documentation

☐All initial screening questions have been reviewed and discussed

Manufacturer:

Dose: ☐ 0.3mL (Pfizer) **Route**: IM
☐ 0.5ml (Moderna)

Site Administered: ☐Right Deltoid ☐Left Deltoid ☐[Other]

Lot Number: _________________ **Expiration Date:** / / **EUA Date:** Pfizer: 12/2020
Moderna: 12/2020

Date Given: / /

Signature: ___________________________________
***Provider signature indicates immunization given according to PHN protocol.*

❑Vaccine NOT given secondary to contraindication: