Effingham County Health Department
COVID-19 Vaccine Consent Form

Vaccine: Moderna or Pfizer
Dose#:

Name (Last)	(First)	(MI)	Date of Birth:	Age:
Address			Daytime Phone Number	

City	State	Zip	Gender:	Race	Ethnic Group: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

	Yes	No
1.) Are you feeling sick today (e.g., cold, fever, acute illness?) *Defer vaccination until after illness.*		
2.) Do you have allergies to any medications, eggs, gelatin, neomycin, baker's yeast, latex, or any other vaccines?		
3.) Have you experienced a severe allergic reaction to any vaccine or an injectable medication in the past? **If yes, you will need to stay 30 minutes for observation after vaccination.**		
4.) In the past two weeks, have you received any vaccination or TB skin test?		
5.) I am pregnant, breastfeeding, or plan to become pregnant in the next 2 months, and I have been counseled by my Obstetrician and/or Pediatrician prior to receiving the COVID-19 vaccine.		
6.) I have had COVID in the past 90 days.		
7.) I have received passive antibody therapy (monoclonal antibodies or convalescent serum) as part of my COVID-19 treatment. **If so, the COVID-19 vaccine should be deferred for at least 90 days**		
8.) Have you received a COVID-19 vaccine? If yes, please circle the brand of vaccine you have received. ☐ J&J ☐ Moderna ☐ Pfizer		
9.) Do you have a bleeding disorder or are you on a blood thinner?		
10.) Are you immunocompromised or are you on a medication that affects your immune system?		

CONSENT FOR VACCINATION:

The purpose of the COVID-19 virus vaccine is to reduce the likelihood of contracting COVID-19. **The FDA continues to evaluate the safety and effectiveness of the vaccines. As of August 23, 2021 the FDA has approved the Pfizer vaccine, and as of January 31, 2022 the FDA has approved the Moderna vaccine.**

The COVID-19 mRNA vaccine is a series of two (2) primary injections, with additional recommended doses per IDPH adoption of the CDC recommendations. Additional doses are spaced apart based on manufacturer and FDA guidelines. Please ensure that you can complete the series before consenting to this vaccine administration.

All vaccines have risks. Possible side effects of the COVID-19 vaccine, while generally inconsequential in adults, can include:

1.) Pain, redness, or swelling around the vaccine site.
2.) Fever, malaise, headache, fatigue, chills, joint pain, and muscular aches. There is a remote risk of a severe allergic reaction.
3.) There may be risks that are not yet known. The FDA continues to evaluate the vaccine and the known side effects are limited based on current data. Additional side effects may become known as the vaccine is used more widely

I consent to the administration of two injections of the COVID-19 virus vaccine. I have read the above statement pertaining to COVID-19 virus vaccine and the Fact Sheet from the manufacturer. I have been advised of and understand the risks, side effects, benefits and alternatives to receiving the vaccine. I understand that there may be risks that are not yet known and other remote risks. I understand the conditions under which the vaccine should not be administered and am unaware of the presence of any of these conditions in myself. I have been advised and understand the vaccine is a series of two injections and I intend to complete the series vaccination. **I understand that I am receiving the vaccine voluntarily and that I have the option to accept or refuse the COVID-19 vaccine at any time, for any reason. I understand that I will not realize the benefit of the vaccine if I decline to receive the second injection.**

- ✓ I have been provided information on V-Safe, a safety monitoring smartphone-based tool managed by CDC, and VaxText Messaging service for second-dose reminders**.**
- ✓ I consent to allow information on this form, as well as the patient registration form, to be entered as necessary in the Illinois Immunization Registry (ICARE).
- ✓ I authorize Effingham County Health Department to bill Medicaid, Medicare, or my Private Insurance for the administration of this vaccine. I understand there will be no cost to me.
- ✓ I authorize Effingham County Health Department to release information regarding my vaccinations to my physician.
- ✓ I have had the opportunity to review the Notice of Privacy Practices.

☐ By checking this box, I am choosing to not wait the recommended 15 minutes after vaccination & have been informed of the risks involved.

Signature: _____ **Date:** _____

For Administrative Use Only

Vaccine	Date Administered	Route	Site	Manufacturer	Lot No./Exp. Date	Name/Title of Vaccinator
COVID-19	/ /	IM	R deltoid L deltoid			