Effingham County Health Department
COVID-19 Vaccine Consent Form

Vaccine:

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.**

The COVID-19 mRNA vaccine was origionally 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.

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 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 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

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			

EZ Encounter_____ EZ Charted_____ IC Checked_____ Scanned_____