Effingham County Health Department
COVID-19 Vaccine Consent Form

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., fever or acute illness?) *Defer vaccination until after illness.*		
2.) Do you have allergies to any medications or any other vaccines? **If yes, you will need to stay for observation after vaccination.**		
3.) 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.		
4.) Do you have a bleeding disorder or are you on a blood thinner?		
5.) 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.**

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 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 is a chance the vaccine may not get covered. If this occurs, Effingham County Health Department is authorized to bill me for the cost of the vaccine.
- 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

Patient Signature: _____ **Date:** _____

For Administrative Use Only

Vaccine	Date Administered	Route	Site	Manufacturer	Exp. Date	Lot #
COVID-19	/ /	IM	R deltoid L deltoid	Moderna		

Nurse's Signature: _____ Date: _____

EZ Encounter: _____ EZ Charted_____ IC Checked_____ Scanned_____