Patient Label
MRN:

DOB:

For LCHC only

Patient COVID19 Vaccination Consent Form

Coronavirus disease 2019 (COVID-19) is an infectious disease caused by the novel coronavirus, SARS-CoV-2, that appeared in late 2019. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have reported a wide range of symptoms, ranging from mild symptoms to severe illness.

Symptoms may appear 2 to 14 days after exposure to the virus. Symptoms may include fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

You should **not** get this vaccine if you:

- Had a severe allergic reaction after a previous dose of this vaccine
- Had a severe allergic reaction to any ingredient of this vaccine
- Are under 18 years of age, as the COVID-19 vaccine is only indicated for individuals 18 years of age or older.

Talk to your doctor about whether you should receive the COVID-19 vaccine if you have any of the following:

- Have any allergies
- Have a fever
- Have a bleeding disorder or are on a blood thinner
- Are immunocompromised or are on a medicine that affects your immune system
- Are pregnant or plan to become pregnant
- Are breastfeeding
- Have received another COVID-19 vaccine

Serious, unexpected and unknown adverse events could occur from receiving the COVID-19 vaccine. The EUA states that side effects that have been reported include injection site pain, tiredness, headache, muscle pain, chills, joint pain, fever, injection site swelling, injection site redness, nausea, feeling unwell, and swollen lymph nodes (lymphadenopathy). There is a remote chance that the COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the COVID-19 Vaccine.

If after vaccination you experience any complications that may be related to the COVID-19 vaccine, contact your doctor and vaccine administrator for potential reporting

- I have read and understand this COVID-19 vaccine consent form
- I have received, read, and understand the Emergency Use Authorization Fact Sheet for Recipients
- I have had the opportunity to discuss any concerns with my doctor
- The administration of the vaccine does not create a patient provider relationship between administrator and recipient
- I understand the risks and benefits of the COVID-19 vaccine
- I am 18 years of age or older
- I did not have a severe allergic reaction after a previous dose of any COVID-19 vaccine
- I do not have a severe allergy to any part of this vaccine
- I understand that my information and vaccination status will be reported to the state
- I freely and voluntarily request to receive the COVID-19 vaccine.

By signing this form, I hereby accept that I have read and understood the acknowledgment letter provided above. I declare that the information I have provided above is correct. I am giving my full consent to get the COVID-19 vaccine of my own will.

Print Name:	Date:
Signature:	

Emergency Documentation Purposes only

☐ First dose ☐ Second dose ☐ Date 1st vaccine received			☐ Moderna
Manufacturer ☐ Moder	Lot #	Expiration Date	Route: IM Left deltoid Right deltoid
Date/Time Vaccine Given:		Printed Name of Vaccine Administrator	