



SECOND DOSE COVID-19 VACCINE CONSENT AND ACKNOWLEDGEMENT FORM

Name: Last:		First:		Middle Initial:			
Date of Birth: Month		Day	Year	Age:	Social Security Number:		
Address:				Phone Number:			
City:		State:		Zip:			
					Yes	No	Don't Know
1. Are you feeling sick today?							
2. Have you ever received a dose of COVID-19 vaccine?							
<ul style="list-style-type: none"> • If yes, which vaccine product did you receive? 							
<input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another product _____							
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)							
<ul style="list-style-type: none"> • A component of a COVID-19 vaccine including either of the following: 							
<ul style="list-style-type: none"> <input type="radio"/> Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures 							
<ul style="list-style-type: none"> <input type="radio"/> Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids. 							
<ul style="list-style-type: none"> • A previous dose of COVID-19 vaccine. 							
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)							
5. Check all that apply to you:							
<input type="checkbox"/> Am a female between ages 18 and 49 years old							
<input type="checkbox"/> Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies							
<input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum							
<input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection							
<input type="checkbox"/> Have a weakened immune system (i.e., HIV infection, cancer)							
<input type="checkbox"/> Take immunosuppressive drugs or therapies							
<input type="checkbox"/> Have a bleeding disorder							
<input type="checkbox"/> Take a blood thinner							
<input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT)							
<input type="checkbox"/> Am currently pregnant or breastfeeding							
<input type="checkbox"/> Have received dermal fillers							
Reviewed by:					Date:		

OFFICE USE ONLY VACCINE NAME: COVID-19			
MANUFACTURER <input type="checkbox"/> Moderna (MOD) <input type="checkbox"/> AstraZeneca (ASZ) <input type="checkbox"/> Johnson & Johnson (JNJ) <input type="checkbox"/> Novavax <input type="checkbox"/> Pfizer (PFR) <input type="checkbox"/> GlaxoSmithKline <input type="checkbox"/> Merck <input type="checkbox"/> Sanofi		DOSE IN SERIES <input type="checkbox"/> First <input type="checkbox"/> Second	DATE OF VACCINATION _____ / _____ / _____
ROUTE OF ADMIN <input checked="" type="checkbox"/> IM <input type="checkbox"/> TD <input type="checkbox"/> IV <input type="checkbox"/> NS <input type="checkbox"/> SC <input type="checkbox"/> ID <input type="checkbox"/> O <input type="checkbox"/> Other	SITE OF INJECTION <input type="checkbox"/> RA <input type="checkbox"/> RD <input type="checkbox"/> RT <input type="checkbox"/> Other <input type="checkbox"/> LA <input type="checkbox"/> LD <input type="checkbox"/> LT _____	SERIES COMPLETE? <input type="checkbox"/> Yes <input type="checkbox"/> No	VACCINATOR