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?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ 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.)			
• A component of a COVID-19 vaccine including either of the following:			
○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
• A previous dose of COVID-19vaccine.			
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:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer)
- ☐ Take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers

Reviewed by: **Date:**

OFFICE USE ONLY VACCINE NAME: COVID-19

MANUFACTURER
☐ Moderna (MOD) ☐ AstraZeneca (ASZ) ☐ Johnson & Johnson (JNJ) ☐ Novavax
☐ Pfizer (PFR) ☐ GlaxoSmithKline ☐ Merck ☐ Sanofi

DOSE IN SERIES
☐ First
☐ Second

DATE OF VACCINATION
_____/_____/_____

ROUTE OF ADMIN
☒ IM ☐ TD ☐ IV ☐ NS
☐ SC ☐ID ☐O ☐Other

SITE OF INJECTION
☐ RA ☐ RD ☐RT ☐Other
☐ LA ☐ LD ☐LT _____

SERIES COMPLETE?
☐ Yes
☐ No

VACCINATOR