



COVID-19 Vaccine Consent Form

Section 1: Information about Person to Receive Vaccine (please print)

CLIENT NAME (Last)	(First)	(MI)	Date of Birth mm/dd/yyyy	Age
Address	City	State	Zip	Phone Number
Race: <input type="checkbox"/> American Indian Alaska Native - Tribe Name: _____ <input type="checkbox"/> Black African American <input type="checkbox"/> Native Hawaiian Pacific Islander				<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Other
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic				<input type="checkbox"/> Male <input type="checkbox"/> Female
Client's Email Address	Client's Authorized POA/Legal Guardian Name		POA/Legal Guardian's Phone #	

Section 2: Screening for Vaccine Eligibility

1-Severe allergic reaction (e.g., anaphylaxis) to a previous dose of COVID-19 vaccine? If yes, please specify:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
2-History of severe allergic reaction (e.g., anaphylaxis) to a component of the COVID-19 vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
3-History of severe allergic reaction (e.g., anaphylaxis) to any other vaccine or injectable therapy (e.g., intramuscular (in the muscle), intravenous (in the vein), or subcutaneous (under the skin))?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
4-Currently ill due to COVID-19?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
5-Received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
6-Exposed to another person with known COVID-19 disease in the last 14 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
7-Have you ever received a dose of COVID-19 vaccine? If yes, which of the following vaccine or dose was provided? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Astra Zeneca <input type="checkbox"/> Johnson & Johnson	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8-Are you pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
9-Have you received any other vaccines (that were not COVID-19) within the past 14 days	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Section 3: Consent

- I acknowledge that I have read or had explained to me the Emergency Use Authorization Fact Sheet for the following COVID-19 vaccine: MODERNA OR JANSSEN. I have also had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described. I request that the COVID-19 vaccine be given to me or to the person named above for whom I am authorized to make this request.
- Information collected on this form will be used to document that you have received vaccine(s). Immunization information may be shared through the Minnesota Immunization Information Connection (MIIC) with other health care providers, schools, health departments, and others authorized under law to receive it. If you have any questions, please ask your health care provider. If you have questions about MIIC, refer to [MIIC and the Public \(www.health.state.mn.us/people/immunize/miic/public.html\)](http://www.health.state.mn.us/people/immunize/miic/public.html) or call 1-800-657-3970.

Signature – Self / POA / Guardian & Date

Signature – Vaccinator / Title

OFFICE USE ONLY			
Date dose #1 Given	Month _____	Day _____	Year _____
Date dose #2 Given	Month _____	Day _____	Year _____
(if applicable)			

OFFICE USE ONLY	
Vaccine Type	COVID - 19
Manufacturer	
Lot Number	
Site	IM – LD IM - RD