COVID–19 Vaccine Consent Form

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

CLIENT NAME (Last)	(Legal First)	(MI)		Date of Birth mm/dd/yyyy	Age
Address	City	State	Zip	Phone Number	☐ Male ☐ Female

Race:	Ethnicity:
☐ American Indian Alaska Native - Tribe Name:______________ ☐ White ☐ Asian ☐ Black African American ☐ Native Hawaiian Pacific Islander ☐ Other	☐ Hispanic ☐ Not Hispanic

Client's Email Address	Client's Authorized POA/Legal Guardian Name	POA/Legal Guardian's Phone #

Section 2: Screening for Vaccine Eligibility

Question			
1-Severe allergic reaction (e.g., anaphylaxis) to a previous dose of COVID-19 vaccine? **If yes, please specify**: ___________________	☐ Yes	☐ No	☐ Unknown
2-History of severe allergic reaction (e.g., anaphylaxis) to a component of the COVID-19 vaccine?	☐ Yes	☐ No	☐ 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))?	☐ Yes	☐ No	☐ Unknown
4-Currently ill due to COVID-19?	☐ Yes	☐ No	☐ Unknown
5-Received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days?	☐ Yes	☐ No	☐ Unknown
6-Exposed to another person with known COVID-19 disease in the last 14 days?	☐ Yes	☐ No	☐ Unknown
7-Have you ever received a dose of COVID-19 vaccine? **If yes, which of the following vaccine or dose was provided?** ☐ Pfizer ☐ Moderna ☐ Astra Zeneca ☐ Johnson & Johnson	☐ Yes	☐ No	
8-Are you pregnant?	☐ Yes	☐ No	☐ Not Applicable
9-Have you been diagnosed with multi-system inflammatory syndrome in the past 90 days?	☐ Yes	☐ No	☐ 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, PFIZER, 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) 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 _______

Date dose #3 Given Month ______ Day _______ Year _______

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