

COVID19 VACCINATION  
CONSENT  
DEWITT- PIATT BI-COUNTY HEALTH DEPARTMENT

PLEASE PRINT CLEARLY!

NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ AGE \_\_\_\_\_

(Person receiving vaccination – Name must match Medicare, Insurance or Medicaid Card)

MAILING ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

Email address: \_\_\_\_\_

PHONE: \_\_\_\_\_ GENDER: MALE FEMALE (circle one)

Race: \_\_\_\_\_ Circle one: Non-Hispanic Hispanic Latino

Occupation: \_\_\_\_\_ Retired: YES No (circle one)

PHYSICIAN: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_

Is the client currently sick or have a fever? Yes \_\_\_\_ No \_\_\_\_

Have you been diagnosed with COVID19? When? \_\_\_\_\_ Yes \_\_\_\_ No \_\_\_\_

Did the client receive a COVID19 vaccination prior to today? Moderna or Pfizer? Yes \_\_\_\_ No \_\_\_\_

Has client ever had an allergic (anaphylactic) reaction to something, or to the COVID19 vaccine or other vaccines? Yes \_\_\_\_ No \_\_\_\_

Does client have a history of Guillain Barre syndrome Yes \_\_\_\_ No \_\_\_\_

Is the person to be vaccinated younger than age 16 or 18? Yes \_\_\_\_ No \_\_\_\_

Does the client have cancer, leukemia, HIV/AIDS or other immune system problems? Yes \_\_\_\_ No \_\_\_\_

Does the client have a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (diabetes), neuromuscular disease, or a blood disorder? Is he/she on long term aspirin therapy? Yes \_\_\_\_ No \_\_\_\_

In the past 3 months has the client taken Prednisone, other steroids, drugs for rheumatoid arthritis, Crohn's disease, or psoriasis, or anti-cancer drugs, anti-viral meds, or radiation treatments? Yes \_\_\_\_ No \_\_\_\_

Is the client breastfeeding, pregnant or could become pregnant in the next month? Yes \_\_\_\_ No \_\_\_\_

Has the client received vaccinations in the past 4 weeks? Yes \_\_\_\_ No \_\_\_\_

Have you received passive antibody therapy as treatment for COVID19 Yes \_\_\_\_ No \_\_\_\_

I have read the information or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of COVID19 vaccine and ask that the vaccine be given to me, or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. I acknowledge I have received, or requested, a copy of the DeWitt-Piatt Bi-County Health Department Notice of Privacy Practices. I agree to wait 15 minutes after vaccine is given to monitor for signs and symptoms of adverse reaction. I consent to have the COVID-19 vaccine administered. I consent to have my vaccination recorded in the State of Illinois registry system I-Care.

X

X

*AUTHORIZING SIGNATURE*

*DATE*

*For office use only below*

EAU GIVEN:

\_\_\_\_ Fact Sheet for Recipients and Caregivers Emergency use Authorization of the Moderna COVID-19 Vaccine

\_\_\_\_ Pfizer-BioNTech COVID19 Fact Sheet for Recipients and Caregivers Emergency use Authorization of the Pfizer-Biotech COVID-19 Vaccine

\_\_\_\_ Janssen COVID19 Fact Sheet for Recipients and Caregivers Emergency use Authorization of the Janssen COVID-19 Vaccine

ROUTE GIVEN IM

SITE: R. DELTOID/THIGH \_\_\_\_\_ L. DELTOID/THIGH \_\_\_\_\_

ADMINISTERED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

Lot # \_\_\_\_\_ Manufacturer \_\_\_\_\_ Exp. Date \_\_\_\_\_

COVID19consents:tc12/20:01/21:02/21:03/21