CIRCLE ONE: 1ST DOSE 2nd DOSE 3rd DOSE BOOSTER DOSE		**Richland County TB & Public Health Office** **Covid -19 Vaccine Consent Form**

NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH** **Sex** **month_____ day_____ year _____Age ___ _ M F**
ADDRESS			**PHONE NUMBER:**
CITY	**STATE**	**ZIP**	**PHYSICIAN:**

ETHNICITY: Hispanic or Latino Not Hispanic or Latino Unknown

RACE: American Indian or Alaska Native Black or African-American Hispanic or Latino
Asian Native Hawaiian or Other Pacific Islander Other race White Unknown

Insurance: Medicare Medicaid Insurance No Insurance

	YES	**NO**
1. Has the person being vaccinated been feeling sick or been running a fever in the last 48 hours? *If yes, defer vaccination.*		
2. Has the person being vaccinated experienced a severe allergic reaction to any ingredient of this vaccine? (*messenger ribonucleic acid (mRNA), lipids (SM-102, polyethylene glycol [PEG] 2000 dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose)*		
3. Has the person being vaccinated experienced a severe allergic reaction to any vaccine or an injectable medication? **If yes, the person being vaccinated will need to stay 30 minutes after vaccination for observation**.		
4. In the past two weeks, has the person being vaccinated received a TB skin test or any other immunization?		
5. Is the person being vaccinated pregnant or breastfeeding?		
6. If yes to the previous question, has the person been counseled by her obstetrician and/or pediatrician prior to receiving the COVID-19 vaccine?		
7. Has the person being vaccinated received passive antibody therapy (monoclonal antibodies or convalescent plasma) as part of COVID-19 treatment? *If yes, defer vaccination for at least 90 days post treatment.*		
8. Has the person being vaccinated received a dose of COVID-19 vaccine? CIRCLE THE BRAND If yes, which brand of Covid -19 vaccine did the person receive? Pfizer Moderna Johnson & Johnson		
9. Does the person being vaccinated have a bleeding disorder or currently on a blood thinner?		
10. Is the person being vaccinated immunocompromised or taking medication that affects the immune system?		
11. Has the person being vaccinated had a positive test for COVID-19?		

CONSENT FOR VACCINATION:

The purpose of the COVID-19 virus vaccine is to reduce the likelihood of contracting COVID-19. **While the FDA has not approved and continues to evaluate its safety and effectiveness, the FDA has authorized the emergency use of it.**

All vaccines have risks. Possible side effects of the COVID 19 vaccine can include:

1. Pain, redness or swelling around the vaccination site.
2. Fever, malaise, headache, fatigue, chills joint pain and muscular aches. There is a remote risk of a severe allergic reaction.
3. There may be risks that are not yet known. The FDA continues to evaluate the vaccine and the known side effects are limited based on current data. Additional side effects may become known as the vaccine is used more widely.
4. I am aware that the adverse reactions to the COVID-19 vaccine, including death, have occurred and have been reported to the Vaccine Adverse Event Reporting System (VARES).

I am aware The Center for Disease Control has stated that the COVID-19 vaccines will not prevent you from being infected with COVID-19 virus or its variants. The Center for Disease Control has also stated that the COVID-19 vaccines will not prevent you from transmitting the COVID-19 virus or its variants.

I consent to and select the following injection of the COVID-19 virus vaccine:

_____ Johnson & Johnson injection _____ Moderna 1st injection _____ Moderna booster injection _____Pfizer 1st injection
_____ Johnson & Johnson booster injection _____ Moderna 2nd injection _____ Moderna booster injection (half dose) ____Pfizer 2nd injection
_____ Pfizer booster

I consent to the administration of the above selected injections of the COVID-19 virus vaccine. I have read the above statement pertaining to COVID-19 virus vaccine and the attached Fact Sheet from the manufacturer.

I have been advised and understand that the Moderna and Pfizer vaccine is a series of two injections and, if I select either the Moderna or the Pfizer, I intend to complete the series vaccination. I understand that I will not realize the benefit of the vaccine if I decline to receive the second injection of either Moderna or Pfizer.

I have read the above statement pertaining to COVID-19 virus vaccine and the attached Fact Sheet from the manufacturer. I have been advised of and understand the risks, side effects, benefits, and alternatives to receiving the vaccine. I understand that there may be risks that are not yet known and other remote risks. I understand the conditions under which the vaccine should not be administered and am unaware of the presence of any of these conditions in myself. **I understand that I am receiving the vaccine voluntarily and that I have the option to accept or refuse the COVID-19 vaccine at any time, for any reason. I understand that I will not realize the benefit of the vaccine if I decline to receive the second injection.**

- I have been provided information on V-Safe, a safety monitoring smartphone-based tool managed by CDC, and VaxText Messaging service for second-dose reminders**.**
- I consent to allow information on this form, as well as the patient registration form, to be entered as necessary in the Illinois Immunization Registry (ICARE). I also authorize Richland County TB & Public Health Office to release my vaccination information to my physician.
- I have been provided with Notice of Privacy Practices.
- I authorize Richland County TB & Health Office to bill Medicaid, Medicare, or my Private Insurance for the administration of this vaccine.
- I will not hold Richland TB & Public Health Board its members, staff or the individual giving the vaccine responsible for any adverse reaction that may result from this vaccination.

Parent/guardian/client

Signature: _____ Date: (month ___ day __ year 2021__)

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date given	Route	Site	Dosage:	Manufacturer	Lot Number\ Exp Date	Name and Title of Vaccine Administrator
COVID-19		IM	R deltoid L deltoid				
Date billed					Procedure		Amount