

<p>CIRCLE ONE:</p> <p>1ST DOSE 2nd DOSE 3rd DOSE BOOSTER DOSE</p>	<p>Richland County TB & Public Health Office Covid -19 Vaccine Consent Form</p>
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NAME (Last)	(First)	(M.I.)	DATE OF BIRTH month _____ day _____ year _____ Age ____ _ M F	Sex 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? <i>If yes, defer vaccination.</i>		
2. Has the person being vaccinated experienced a severe allergic reaction to any ingredient of this vaccine? (<i>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</i>)		
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? <i>If yes, defer vaccination for at least 90 days post treatment.</i>		
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?		

