Carolina Family Health Centers, Inc.

Wilson County Health Department

COVID-19 Vaccination Consent Form

Today's Date: _____

Patient Information

Patient Name: _____
First Name *Middle Name* *Last Name*

Gender at Birth: ☐Male ☐Female **Date of Birth:** _____/_____/_____
Month *Day* *Year*

Address

Physical Address:_____

County of Residence: ☐Edgecombe ☐Nash ☐Wilson ☐Other**:** _____

Contact Information

Please indicate your primary phone number by checking the box below:

☐ Cell phone **(**_____**)** _____ ☐ Home **(**_____**)** _____

Additional Information

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown ☐ Refuse to answer

Race: ☐Asian ☐Black/African American ☐Native American ☐White ☐Other _____
☐Unknown ☐ Refuse to answer

Primary (or Preferred?) Language: ☐English ☐Spanish ☐Other: _____

Employment: Who is your employer:_____

Farmworker Status:
In the past 24 months, did you or a member of your family move here or somewhere else to do farm work?
☐ Yes ☐ No

If yes, do you work ☐ seasonally (I do other work during the winter months, i.e. construction, etc.) or
☐ I only work in agriculture

Health History:
How many high-risk chronic conditions do you have? Review the CDC Website for definitions of the conditions that cause higher risk of contracting COVID-19.
☐ None ☐ 1 ☐ 2 or more

PREVACCINATION CHECKLIST

Are you feeling sick today? ☐ Yes ☐ No

Have you ever received a dose of COVID-19 vaccine?
If yes, which vaccine product did you receive? ☐ Yes ☐ No
_____

The following questions relate to allergic reactions you may have experienced in the past. This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.

Have you ever had an allergic reaction to a component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures?	☐ Yes ☐ No
Have you ever had an allergic reaction to Polysorbate which is found in some vaccines, film coated tablets, and intravenous steroids?	☐ Yes ☐ No
Have you ever had an allergic reaction to a previous dose of COVID-19 vaccine?	☐ Yes ☐ No
Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	☐ Yes ☐ No
Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	☐ Yes ☐ No
Have you received any vaccine in the last 14 days?	☐ Yes ☐ No
Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? *If yes, when?_____	☐ Yes* ☐ No
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐ Yes ☐ No
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐ Yes ☐ No
Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes ☐ No
Are you pregnant or breastfeeding?	☐ Yes ☐ No
Do you have dermal fillers?	☐ Yes ☐ No

I certify that I am at least 18 years of age and I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an "applicable Provider"), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine. I have been provided with the benefits and potential adverse reactions of receiving the COVID-19 vaccine, have had the opportunity to ask questions and understand the benefits and potential risks of the vaccine, and give my consent to receive the vaccine. I further understand, as with all medical treatments, I may experience an adverse side effect from the vaccine. I have been given the Emergency Use Authorization (EUA) of the Moderna COVID-19 Vaccine fact sheet.

_____ _____

Patient or Guardian Signature **Date**

TO BE COMPLETED BY HEALTHCARE PROVIDER

Vaccine Administration Details

COVID-19 Vaccine: Moderna Lot Number: _____ Exp:_____

Site of Injection: (Circle) Right or Left Deltoid

Vaccine administered by: _____Date: _____