

# COVID-19 Screening and Consent Form

Please print

## Section 1: Vaccine Recipient Information

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State ZIP

Date of birth: \_\_\_\_\_ Phone number: \_\_\_\_\_

### Race

- American Indian or Alaska Native  Black or African American  
 Asian  White  
 Native Hawaiian  Other Race  
 Other Pacific Islander

### Ethnicity

- Not Hispanic or Latino  Hispanic or Latino

### Primary Language

- English  Spanish

Administered at: \_\_\_\_\_

## Section 2: Screening Questionnaire

Are you feeling sick today? YES  NO

Have you been treated with antibody therapy for COVID-19 in the past 90 days? YES  NO

Have you had a serious or life-threatening allergic reaction, such as hives, or difficulty breathing to *any* vaccine or shot? YES  NO

Have you had any vaccines in the past 14 days? (Including flu shot) YES  NO

Are you pregnant, considering becoming pregnant or breast feeding? YES  NO

Do you have cancer, leukemia, HIV/AIDS, history of autoimmune disease or any other conditions that weakens the immune system? YES  NO

Do you take any medications that affect your immune system such as steroids, anticancer drugs or have you had any radiation treatments? YES  NO

## Emergency use authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or licensed vaccine. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

## Consent

I have received, read, or had explained to me, and understand the COVID-19 vaccine information sheet provided. I hereby authorize \_\_\_\_\_ to administer the vaccine I have requested as two-dose series \_\_\_\_\_ days apart. The scope of this consent includes administration of the vaccine, discussion with a provider if requested, care and treatments immediately after administration as needed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Section 3: To be completed by vaccinator

\_\_\_\_\_  
Administrator

Vaccine administered:	First dose	Second dose
_____	<input type="checkbox"/>	<input type="checkbox"/>
Administration site:	L deltoid	R deltoid
_____	<input type="checkbox"/>	<input type="checkbox"/>