Lehigh Valley Health Network

# 2020-2021 Consent for COVID-19 Vaccine

1. **Last Name** _____ **First Name** _____
2. **Date of Birth**_____
3. **Social Security #** _____ 4. **Gender: Male/Female/Nonbinary/Unknown (circle one)**

| **Screening:** | **Yes** | **No** |
|---|---|---|
| Was the EUA sheet given to you today? | ☐ | ☐ |
| Have you ever had an anaphylactic reaction to a vaccine or injectable therapy in the past? | ☐ | ☐ |
| Do you have an anaphylactic allergy to polysorbate or polyethylene glycol? | ☐ | ☐ |
| Do you have a fever (temperature >100.4), or are you sick today with a moderate to severe illness? (e.g. fever) …….. | ☐ | ☐ |
| Are you pregnant, breastfeeding or planning to be pregnant in the next 28 days? | ☐ | ☐ |
| Are you experiencing any COVID-19 symptoms (shortness of breath, cough, fever, unexplained muscle soreness or extreme fatigue, sore throat, congestion, loss of sense of smell or taste), or have you been in contact with a known COVID positive person in the last 14 days? … | ☐ | ☐ |
| Have you had a vaccine within the past 14 days or plan to get a vaccine in the next 14 days? | ☐ | ☐ |
| Have you received monoclonal antibody for COVID-19 in the past 90 days? | ☐ | ☐ |

4. **Participant Informed Consent Signature**
   - I have received and read the EUA vaccine information sheet regarding the benefits and risks of receiving the COVID-19 vaccine.
   - If pregnant and/or undergoing fertility treatment, I have discussed receiving a COVID-19 vaccine with my treating physician and have been approved to receive the COVID-19 vaccine
   - I have had the opportunity to have my questions answered regarding the vaccine
   - I consent to be immunized
   - I understand that in order to assure that my personal medical record reflects my receipt of the COVID-19 vaccine, confirmation of this vaccine will be documented in my personal EPIC medical record.

**Signature:** _____ **Date:** _____

☐ ***I fully understand and agree to the above authorization. My typed name above shall have the same force and effect as my written signature.***

If under 18, parental consent required. **Parent signature:** _____

☐ ***I fully understand and agree to the above authorization. My typed name above shall have the same force and effect as my written signature.***

**Witness to parental signature:** _____ **Date:** _____

## For Internal (Vaccinator) Use Only

| **Vaccine** | **Manufacturer** | **Dose** | **Route** | **Site** | | **Lot #** | **Exp. Date** |
|---|---|---|---|---|---|---|---|
| ☐ COVID-19 EUA | Pfizer | 0.3ml | IM | ☐ L delt | ☐ R delt | _____ | _____ |
| ☐ COVID-19 EUA | Moderna | 0.5ml | IM | ☐ L delt | ☐ R delt | _____ | _____ |

**Vaccinator Signature** _____ **Date:** _____