Marquette University COVID-19 Vaccine Administration Record and Consent

Name: _____ DOB: _____ Race:_____

Address: _____ City: _____ State:_____

Phone: _____ Email: _____

MUID: _____ Allergies: _____

PRECAUTIONS: (Yes answers must be discussed with a nurse prior to vaccination)

Have you received a prior dose of the COVID-19 vaccine?	**YES**	**NO**
• If yes, Date of vaccine _____ Manufacturer _____		
Have you had a severe allergic reaction to any of the following, (This would include a severe allergic reaction 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.)	**YES**	**NO**
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG) which is found in some medications, such as laxatives and preparations of colonoscopy procedures	**YES**	**NO**
• Polysorbate	**YES**	**NO**
• A previous dose of COVID-19 vaccine	**YES**	**NO**
• Another vaccine or an injectable medication	**YES**	**NO**
• Any food, pet, environmental, or oral medication	**YES**	**NO**
Do you have an acute illness and/or fever (>100.0 degrees F) today?	**YES**	**NO**
Have you received any vaccine in the last 14 days?	**YES**	**NO**
Have you had a positive test for COVID-19 or has a doctor told you that you had COVID-19?	**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 blood thinners?	**YES**	**NO**
Are you pregnant or breastfeeding?	**YES**	**NO**

I have read and received a copy of the FDA's Emergency Use Authorization Fact Sheet about the COVID-19 Vaccine. I have had the opportunity to ask questions and I understand the risks and the benefits of the vaccine and the alternative modes of treatment. I expressly consent to and request that the vaccine be given to me. I authorize the disclosure of my vaccine information to the Wisconsin Immunization Registry (WIR) and the CDC. I hereby release Marquette University and its affiliates, officers, directors, employees and agents from all liability or claim for loss, injury or illness arising from this vaccination on behalf of myself and my personal representatives, heirs and assigns, and I understand that this release excludes any harm or loss caused intentionally or recklessly by Marquette. I also waive the right to bargain for different release of liability terms.

SIGNATURE: _____DATE: _____

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Vaccination Date: _____/_____/_____ Dose #1 of 2 ____ Right Deltoid _____ Left Deltoid_____

Vaccination Date: _____/_____/_____ Dose #2 of 2 ____ Right Deltoid _____ Left Deltoid_____

Product/Manufacturer Name: _____ Lot: _____

Vaccinator: _____ Clinic Site: Marquette University Medical Clinic

1/20/21 LC/JS