NWMS NORTHWEST MEDICAL SPECIALTIES, PLLC

COVID-19 Vaccine Consent Form

1. Are you feeling sick today?	Yes	No
2. Have you ever received a dose of COVID-19 Vaccine?	Yes	No
3. If yes, which vaccine product did you receive?	Pfizer	Moderna
4. Have you had a severe allergic reaction to: (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)		
a. 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
b. Polysorbate	Yes	No
c. A previous dose of COVID-19 vaccine	Yes	No
5. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (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)	Yes	No
6. Do you have allergies or reactions to any medications, foods, or latex? If so, please explain	Yes	No
7. Have you received any vaccine in the last 14 days?	Yes	No
8. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	Yes	No
9. Are you immunocompromised or on a medicine that affects your immune system?	Yes	No
10. Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No
11. Are you pregnant or breastfeeding?	Yes	No

- I understand and acknowledge: a) the risks of receiving a COVID-19 vaccination; b) that it is possible not all risks and side effects of said vaccine are fully known at this time; c) the COVID-19 vaccination will be administered pursuant to an Emergency Use Authorization, and not pursuant to an FDA approval or clearance; d) have received, read, and/or had explained to me the Fact Sheet for Recipients and Caregivers, Emergency Use Authorization (EUA) of COVID-19 Vaccine to Prevent Coronavirus Disease 2019 of the vaccine I have elected to receive; e) the COVID-19 vaccination is administered in two separate doses and may not be effective if I do not receive both doses; and f) that my personal health data related to the use, administration, and/or receipt of the COVID-19 vaccination may be reported to the state of Washington.
- I certify that I am: a) the patient and at least 18 years of age; b) the legal guardian of the patient and confirm that the patient is at least 16 years of age; or c) authorized to consent for vaccination for the patient named above.

Name (printed): _____ Date of Birth: _____

Signature: _____ Date: _____

Injection Site: _____ Time: _____ Vaccinator: _____