Hunterdon County Health Department
COVID-19 Vaccine Consent Form

I have read, or have had explained to me, the information provided about the COVID-19 vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and the risks of this vaccine, and request that one be given to me or the person named below for whom I am authorized to make this request. I agree to hold the Hunterdon County Health Department, its agents, and the County of Hunterdon, harmless for any claims arising from receipt of this vaccine.

I acknowledge receipt of the COVID-19 Emergency Use Authorization (EUA) Patient Fact Sheet

_____ _____

PRINT Name Date

❑ **COVID-19 Vaccine**

Please provide your healthcare provider information:

MD _____

Address_____

In the past 2 weeks have you tested positive for COVID-19 or are you currently being monitored for COVID-19?	**YES**	**NO**
In the past 2 weeks have you had contact with anyone who has tested positive for COVID-19?	**YES**	**NO**
Do you currently have or have you in the past 14 days had a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?	**YES**	**NO**
Are you feeling sick today?	**YES**	**NO**
Do you have any anaphylactic reactions to any foods, medications, vaccines or latex, any history of anaphylaxis? **IF YES MUST WAIT FOR 30 MINUTES AFTER RECEIVING VACCINE**	**YES**	**NO**
Have you ever had a serious reaction after receiving a vaccine? Has any physician or healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	**YES**	**NO**
Do you have any history of seizure, brain or other nervous system problem? **IF YES MUST HAVE SIGNED LETTER OF CLEARANCE FROM YOUR HEALTHCARE PROVIDER**	**YES**	**NO**
Do you have a history of Guillain Barre? **IF YES NOT ELIGIBLE TO RECEIVE VACCINE**	**YES**	**NO**
Are you on blood thinning medications or have a bleeding disorder? **NOT A CONTRAINDICATION. WATCH FOR BLEEDING AT INJECTION SITE**	**YES**	**NO**
Are you under 18 years old? **IF YOU ARE UNDER 18 YOU CANNOT RECEIVE THE MODERNA VACCINE**	**YES**	**NO**
Are you on a medication that effects your immune system or have any medical issue that effects your immune system such as HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Chron's or other immune system problem? **IF YOU TAKE A MEDICATION THAT EFFECTS YOUR IMMUNE SYSTEM OR HAVE A MEDICAL ISSUE THAT EFFECTS YOUR IMMUNE SYSTEM YOU MUST HAVE A SIGNED LETTER OF CLEARANCE FROM YOUR HEALTHCARE PROVIDER**	**YES**	**NO**
During the past year have you received a transfusion of blood or blood products, been given immune gamma globulin or an antiviral drug? **IF YES MUST HAVE SIGNED LETTER OF CLEARANCE FROM YOUR HEALTHCARE PROVIDER**	**YES**	**NO**
Have you received any vaccinations the past 14 days?	**YES**	**NO**
Are you pregnant or plan on becoming pregnant? **IF YOU ARE PREGNANT OR BREASTFEEDING YOU MUST HAVE SIGNED LETTER OF CLEARANCE FROM YOUR MEDICAL PROVIDER.**	**YES**	**NO**
Are you breastfeeding?	**YES**	**NO**
Have you already received another brand of Covid Vaccine?	**YES**	**NO**

Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Phone _____ Birth Date ____/ ____/ _____ Age:_____ Sex: M F

X_____ _____

Signature of person to receive vaccine(s) or the person authorized to make this request. Date

DID YOU SIGN YOUR FORM???

PLEASE DO NOT WRITE BELOW THIS LINE

Vaccination Date :

Site of Injection: Deltoid IM (circle one) Left Right

COVID-19: Moderna Lot #

Exp date:

Initial or 2nd Dose –

GIVEN BY: _____