Piedmont Medical Center

Version 1
1.12.21

COVID-19 Vaccine Consent

☐ First Dose ☐ Second Dose

Type of vaccine for first dose: ☐ Pfizer ☐ Moderna Date first dose received: _____

Name:_____ Date:_____ Date of Birth:_____

Address:_____

Email:_____ Phone Number:_____

If you had a severe allergic reaction to the first dose, tell your vaccine administrator and **DO NOT TAKE THE SECOND DOSE.**

Coronavirus disease 2019 (COVID-19) is an infectious disease caused by the novel coronavirus, SARS-CoV-2, that appeared in late 2019. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have reported a wide range of symptoms, ranging from mild symptoms to severe illness.

Symptoms may appear 2 to 14 days after exposure to the virus. Symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

You should not get this vaccine if you:

- had a severe allergic reaction after a previous dose of this vaccine
- had a severe allergic reaction to any ingredient of this vaccine
- do not meet the age indications (≥16 years of age for Pfizer's vaccine or ≥18 years of age for Moderna's vaccine)

Talk to your doctor about whether you should receive the COVID-19 vaccine if you have any of the following:

- have any allergies
- have a fever
- have a bleeding disorder or are taking a blood thinner
- are immunocompromised or are receiving a medicine that affects your immune system
- are pregnant or plan to become pregnant
- are breastfeeding
- have received another COVID-19 vaccine

Serious, unexpected and unknown adverse events could occur from receiving the COVID-19 vaccine and may be more frequent after dose 2 than dose 1. The EUAs state that side effects that have been reported include: **Injection site reactions**: pain, swelling (hardness), redness, tenderness and swelling of the lymph nodes. **General side effects**: tiredness/fatigue, feeling unwell, headache, muscle pain, joint pain, chills, nausea, vomiting, and fever. There is a remote chance that the COVID-19 Vaccine could cause a severe allergic reaction. Signs of a severe allergic reaction can include: difficulty breathing, swelling of your face and throat, a fast heartbeat, a bad rash all over your body, dizziness and weakness.

A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the COVID-19 Vaccine.

If after vaccination you experience any complications that may be related to the COVID-19 vaccine, contact your doctor and vaccine administrator for potential reporting.

- I have read and understand this COVID-19 vaccine consent form.
- I have received, read, and understand the Emergency Use Authorization Fact Sheet for Recipients.
- I have had the opportunity to discuss any concerns with my doctor.
- The administration of the vaccine does not create a patient provider relationship between administrator and recipient.
- **I** understand the risks and benefits of the COVID-19 vaccine.
- I meet the age requirement for the vaccine I am being given, as outlined above.
- I did not have a severe allergic reaction after a previous dose of any COVID-19 vaccine.
- I do not have a severe allergy to any part of this vaccine.
- I understand that my information and vaccination status will be reported to the state.
- I understand I need to remain for observation (15 minutes or 30 minutes with history of anaphylactic reaction due to any cause).
- I freely and voluntarily request to receive the COVID-19 vaccine.

Signature or Parental Consent Signature:_____ Date:_____

Manufacturer _____ Lot # _____ Exp. Date _____

Route IM **(circle one)** Left deltoid Right deltoid Date/Time Vaccine Given _____

Printed Name of Vaccine Administrator _____