Waukesha County COVID-19 Vaccine Consent Form

Section 1: Information about Patient to Receive Vaccine (please print)

PATIENT NAME (Last)		(First)	(M.I.)	**Patient Mobile Phone Number** ( )
ADDRESS				**PATIENT DATE OF BIRTH** **month_____ day_____ year _____**
CITY	**STATE**	**ZIP**		**AGE: _____ - No Pfizer vaccine if <16**
EMAIL				**Mothers Maiden Name**

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if you can get the COVID-19 vaccine. If you answer "NO" to all of the questions you can receive the COVID-19 vaccine. If you answer "YES" to any question, you may be able to get the COVID-19 vaccine, but additional questions may be asked. Please mark YES or NO for each question.

	YES	NO
1. Are you feeling sick today? Mild illnesses (eg upper respiratory, infections) are NOT contraindications to vaccination	☐	☐
2. Have you ever received a dose of COVID-19 Vaccine? If Yes: ☐ Pfizer ☐ Moderna ☐ Other_____ ** Todays Vaccine must be same type as initial dose**	☐	☐
3. Have you ever had an 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 component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures – If yes, NO Vaccination	☐	☐
• Polysorbate – If yes, NO vaccination	☐	☐
• A previous dose of COVID-19 vaccine – If yes, NO vaccination	☐	☐
4. 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.)	☐	☐
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies. – If yes, individual should be observed for 30 min after vaccination	☐	☐
6. Have you received any vaccine in the last 14 days? If yes, NO vaccination	☐	☐
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? No Vaccine until patient is outside of the quarantine window	☐	☐
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? If yes, vaccination should be delayed 90 days post treatment	☐	☐
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? If yes, patient should consult their Dr. prior to obtaining vaccination	☐	☐
10. Do you have a bleeding disorder or are you taking a blood thinner? If yes, apply direct pressure for 2 minutes	☐	☐
11. Are you pregnant or breastfeeding? If yes, patient should consult their Dr. prior to obtaining vaccination	☐	☐

Section 3: Consent

CONSENT FOR VACCINATION: I have read or had explained to me the Vaccine Information Statement for the COVID-19 vaccine and understand the risks and benefits and:

☐ **I GIVE CONSENT** to the Western Lakes Fire District staff or affiliate to administer the COVID-19 vaccine to me.

Signature of Patient _____Date:_____

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
COVID-19 ☐ **IM**	☐ **RD** ☐ **LD**	/ /			