MONROE COUNTY HEALTH DEPARTMENT
COVID-19 Vaccine Consent Form 2020-2021: INJECTION

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

NAME (Last)	(First)	(M.I.)	DATE OF BIRTH month_____ day_____ year _____
STREET ADDRESS		AGE	GENDER MALE FEMALE
City	State	Zip Code	Phone

Section 2: Screening for Vaccine Eligibility: MUST answer YES or NO for each question.

	YES	NO
1. Do you have a weakened immune system caused by conditions such as HIV, cancer, or take immunosuppressive drugs or therapies?		
2. Have you ever received a dose of COVID-19 vaccine? If yes, which kind? _____	YES	NO
3. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	YES	NO
4. Have you ever had a severe allergic reaction (e.g., anaphylaxis, trouble breathing, throat closing) to any vaccine?	YES	NO
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	YES	NO
6. Have you received another vaccine within the past 14 days?	YES	NO
7. Do you have a bleeding disorder or are you taking a blood thinner?	YES	NO
8. Are you receiving any antiviral medications (e.g., Tamiflu, Valtrex)?	YES	NO
9. Are you pregnant or breastfeeding?	YES	NO
10. Do you have a history of fainting/passing out with needles or shots?	YES	NO
11. Are you sick today?	YES	NO

PLEASE NOTE: You must be monitored for 15 minutes after vaccination for any adverse reaction. Some situations may require monitoring for 30 minutes. If you leave prior to the recommended monitoring time, the Monroe County Health Department is not responsible.

Section 3: CONSENT FOR VACCINATION:

I have been provided the vaccination fact sheet for the COVID-19 vaccine and understand the risks and benefits. By signing this consent form below, **I GIVE CONSENT** to the MONROE COUNTY HEALTH DEPARTMENT and its staff for the person named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then person will not be vaccinated)

Signature of Patient _____ **Date: month**_____ **day**____ **year** _____

Section 4: Vaccination Record -FOR ADMINISTRATIVE USE ONLY

Vaccine	Route	Date Dose Administered	Site	Lot Number	Name and Title of Vaccine Administrator
Pfizer	IM		Deltoid		
Moderna			R		
J & J			L		