COVID 23/24

MONROE COUNTY HEALTH DEPARTMENT
COVID-19 Vaccine Consent Form 2023-2024

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 At BIRTH 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 any of the following: asthma, diabetes (or other type of metabolic disease), disease of the lungs, heart, kidneys, liver, nerves, blood, or a weakened immune system (e.g. HIV, cancer, or taking medications such as steroids or those used to treat cancer)?		
2. Have you ever received a dose of the COVID vaccine? If yes, which kind?	YES	NO
3. Have you received a positive COVID test in the past 10 days?	YES	NO
4. Have you ever had a severe allergic reaction to any vaccine (e.g. anaphylaxis, trouble breathing, throat closing)?	YES	NO
5. Have you received passive antibody therapy as treatment for COVID (e.g. monoclonal antibodies or convalescent serum)?	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 antiviral medications (e.g. Paxlovid, Valtrex, Tamiflu, Relenza, etc.)?	YES	NO
9. Are you pregnant or breastfeeding?	YES	NO
10. Do you have a history of fainting/passing out from 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 to me for the COVID 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. **CONSENT FORM MUST BE SIGNED.**

Signature of Patient _____ **Date: Month** _____ **Day** ____ **Year** _____

Section 4: Vaccination Record - FOR ADMINISTRATIVE USE ONLY

VIS Date:

Vaccine	Route	Date Dose Administered & VIS Given	Site	Lot Number	Name and Title of Vaccine Administrator
Pfizer Moderna Pediatric	IM Monovalent VFC BRIDGE		Deltoid R L		