**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: Vaccination Fee – (Check only ONE box for your child)**

* **MEDICAID (VFC ONLY) Insurance & Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **NO Insurance OR Insurance does NOT cover cost of vaccinations**

**Section 3: Screening for Vaccine Eligibility: MUST answer YES or NO for each question.**

|  |  |  |
| --- | --- | --- |
| 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)? | **YES** | **NO** |
| 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 4: 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 \_\_\_\_\_\_\_**

**VIS Date:**

**Section 5: Vaccination Record - FOR ADMINISTRATIVE USE ONLY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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 |  |  |
|  |  |  |  |  |  |

02/2024 MONROE COUNTY HEALTH DEPARTMENT, WATERLOO, IL