



Wilson County Health Department

1801 Glendale Drive SW • Wilson, NC 27893-4401 • Phone 252.237.3141

COVID-19 VACCINATION CONSENT FORM

*Patient Full Name: _____ AGE: _____

*Full Name (Printed): _____

Parent/Legal Guardian: _____

*Address: _____ *County: _____

*Phone Number: _____ CITY/ZIP CODE _____ *Gender: _____

*DOB: _____ Email: _____

Social Security #: _____ Preferred Language: _____

***Race:** _____

***Ethnicity:** (Circle) Hispanic Non-Hispanic

PAYOR:

MEDICARE PART B # _____

MEDICAID # _____

INSURANCE NAME & POLICY # _____

SELF PAY \$ _____

I authorize the Wilson County Health Department to file any applicable visits to my insurance company.

Place of Employment: _____

Have you tested positive for COVID-19 in the last 30 days? YES or NO

How many high-risk chronic conditions do you have? Review the CDC Website for definitions of the conditions that cause higher risk of contracting COVID 19 (Circle)

None 1 2 or more

CONSENT FOR IMMUNIZATIONS

I have read or have had explained to me about the COVID-19 and the COVID-19 vaccine. I have had the opportunity to ask questions and understand the benefits and risks of the COVID-19 vaccine. I further understand, as with all medical treatments, I may experience an adverse side effect from the vaccine. I grant permission to Wilson County Health Department to administer the vaccine to myself and/or for my child/dependent. I have been given the Emergency Use Authorization (EUA) of Moderna/Pfizer COVID-19 Vaccine fact sheet.

Signature: _____ **Date:** _____

Parent/Guardian: _____ **Date:** _____

<u>Employee Health Use Only</u>		
<u>COVID-19 Vaccine</u>	<u>Lot #</u> _____	<u>Site of Injection</u>
<u>2020-2021</u>	<u>Exp:</u> _____	Right or Left Deltoid
<u>MODERNA/PFIZER</u>		

Provider Signature : _____ **Date:** _____

For Vaccine Recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you feeling sick today			
2. Have you ever received a dose of COVID-19 vaccine? <ul style="list-style-type: none"> • If yes, which vaccine product did you receive? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Another product 			
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.)			
<ul style="list-style-type: none"> • A component of the COVID-19 vaccine includes polyethylene glycol (PEG), which is found in some medications such as laxatives and preparations for colonoscopy procedures. 			
<ul style="list-style-type: none"> • Polysorbate 			
<ul style="list-style-type: none"> • A previous dose of COVID-19 vaccine 			
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 other medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
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?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			

Form reviewed by
 (Initial): _____