Valley Baptist Health System

COVID-19 Vaccine Consent

☐ First Dose ☐ Second Dose

Type of vaccine for first dose: ☐ Pfizer ☐ Moderna Date first dose received: _____

First Name:_____ Last Name: _____ Date of Birth:_____

Address:_____ County: _____

Email:_____ Gender: _____ Phone Number: _____ _____

Facility/Organization where you primarily work:_____ Mother's First Name: _____

If you had a severe allergic reaction to the first dose, tell your vaccine administrator and **DO NOT TAKE THE SECOND DOSE.**

EEO: ☐White ☐Asian ☐Hispanic/Latino ☐Black/African American ☐American Indian/Alaskan Native
☐Native Hawaiian/Pacific Islander ☐Two or More Races Gender: ☐Male ☐Female ☐Other

EEO tracking information is required by states and will not be used for any other purposes

Coronavirus disease 2019 (COVID-19) is an infectious disease caused by the novel coronavirus, SARS-CoV-2, that appeared in late 2019. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have reported a wide range of symptoms, ranging from mild symptoms to severe illness.

Symptoms may appear 2 to 14 days after exposure to the virus. Symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

You should <u>not</u> get this vaccine if you:

- had a severe allergic reaction after a previous dose of this vaccine
- had a severe allergic reaction to any ingredient of this vaccine
- are under 16 years of age, as the COVID-19 vaccine is only indicated for individuals 16 years of age or older.

Talk to your doctor about whether you should receive the COVID-19 vaccine if you have any of the following:

- have any allergies
- have a fever
- have a bleeding disorder or are on a blood thinner
- are immunocompromised or are on a medicine that affects your immune system
- are pregnant or plan to become pregnant
- are breastfeeding
- have received another COVID-19 vaccine

Serious, unexpected and unknown adverse events could occur from receiving the COVID-19 vaccine. The EUA states that side effects that have been reported include: injection site pain, tiredness, headache, muscle pain, chills, joint pain, fever, injection site swelling, injection site redness, nausea, feeling unwell, and swollen lymph nodes (lymphadenopathy). There is a remote chance that the COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the COVID-19 Vaccine.

If after vaccination you experience any complications that may be related to the COVID-19 vaccine, contact your doctor and vaccine administrator for potential reporting.

- I have read and understand this COVID-19 vaccine consent form.
- I have received, read, and understand the Emergency Use Authorization Fact Sheet for Recipients.
- I have had the opportunity to discuss any concerns with my doctor.
- The administration of the vaccine does not create a patient provider relationship between administrator and recipient.
- I understand the risks and benefits of the COVID-19 vaccine.
- I am 16 years of age or older.
- I did not have a severe allergic reaction after a previous dose of any COVID-19 vaccine.
- I do not have a severe allergy to any part of this vaccine.
- I understand that my information and vaccination status will be reported to the state.
- I freely and voluntarily request to receive the COVID-19 vaccine.

Signature or Parental Consent Signature:_____ Date:_____

<u>To be completed by Valley Baptist Vaccination Station Personnel:</u>

Manufacturer _____ Lot # _____ Exp. Date _____

Route <u>IM</u> **(circle one)** Left deltoid Right deltoid Date/Time Vaccine Given _____

Printed Name of Vaccine Administrator _____