Date: _____ Patient's Name (Printed): _____

Have you received the COVID-19 Vaccine before? **_____ Yes _____ No**

If yes, which vaccine product did you receive?

____ Pfizer ____ Moderna

____ Another Product _____

Are you younger than 18 years of age? **_____ Yes _____ No**

Have you received any vaccine in the last 14 days? **_____ Yes _____ No**

Have you received passive antibody therapy as treatment for COVID-19? **_____ Yes _____ No**

This includes monoclonal antibodies or convalescent serum.

Have you had an allergic reaction to a COVID-19 vaccine, polysorbate or any components of the vaccine such as polyethylene glycol (PEG)? **_____ Yes _____ No**

This would include a severe allergic reaction requiring an Epipen or causing hospitalization or any allergic reaction causing hives, selling or respiratory distress. Polyethylene glycol is found in some medications including laxatives and colonoscopy preparations.

Have you had a severe allergic reaction to any other injectable medication (intramuscular, subcutaneous, intravenous) in the past? **_____ Yes _____ No**

COVID VACCINE – Consent (16 years of age and older)

I have been informed that the COVID-19 vaccine is an unapproved vaccine that has been authorized for use by the FDA under Emergency Use Authorization. I have received the "Fact Sheet for Recipients and Caregivers". I understand that the COVID-19 vaccine is not mandatory. I understand the significant known and potential risks/benefits of the COVID-19 vaccine, and the extent to which such risks and benefits are unknown. I have been notified about available alternative vaccines and the risks and benefits of those alternatives.

_____ _____

Patient or Parent/Caregiver Signature **Date**

Patient Name (Print): _____ MRN# (if applicable): _____

RD: ____ LD: _____

Nurse/MA (Print): _____

Date: _____