Crawford County
Home Health, Hospice & Public Health

COVID-19 Vaccine Consent

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Number: _____ Cell Number: _____

Gender: ☐ Female ☐ Male Medical Provider: _____

Dose #1 Screening

Are you feeling sick today?	☐ Yes	☐ No	☐ Don't Know
Have you received a COVID-19 vaccine previously? If yes: Date 1st Dose: _____Date 2nd Dose: _____ If yes: Which vaccine? ☐ Pfizer ☐ Moderna ☐ Other:	☐ Yes	☐ No	☐ Don't Know
Have you ever had a severe allergic reaction (anaphylaxis) that required treatment with epinephrine or EpiPen or required hospitalization?	☐ Yes	☐ No	☐ Don't Know
Was this severe allergic reaction after receiving a COVID-19 vaccine?	☐ Yes	☐ No	☐ Don't Know
Was this severe allergic reaction after receiving another vaccine or injectable medication?	☐ Yes	☐ No	☐ Don't Know
Have you received antibody therapy (such as convalescent plasma) as treatment for COVID-19?	☐ Yes	☐ No	☐ Don't Know
Have you received another vaccine in the last 14 days?	☐ Yes	☐ No	☐ Don't Know
Have you tested positive for COVID-19? If yes: Date	☐ Yes	☐ No	☐ Don't Know
Do you have a weakened immune system (such as HIV or cancer) or do you take immuno-suppressive drugs or therapies?	☐ Yes	☐ No	☐ Don't Know
Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes	☐ No	☐ Don't Know
Are you pregnant or breastfeeding?	☐ Yes	☐ No	☐ Don't Know

By signing the consent, I acknowledge that I understand the following:

- The FDA has authorized the emergency use of the Moderna COVID-19 Vaccine that may prevent COVID-19. This vaccine is not FDA-approved. There is no FDA-approved vaccine to prevent COVID-19. The FDA has authorized the emergency use of this vaccine for individuals age 18 and older.
- V-safe is a smart-phone based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after receiving the vaccine. I understand that participation with V-safe is voluntary and that I must enroll myself.
- This vaccine is a 2-dose series and I must receive both doses in order to achieve the best immunity. I need to make sure that I receive that second dose as close to 28 days after my first dose as possible.

Vaccination Release

I have read or have had explained to me the information on the Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS). I have had a chance to ask questions that were answered to my satisfaction. I consent to the vaccine be given to me or to the person for whom I am authorized to make this request. I will not hold Crawford County Board of Supervisors, Crawford County Board of Health, or Crawford County Home Health, Hospice & Public Health agency or staff responsible for any reaction or adverse effects of this vaccine.

Printed name: _____ Signature: Typed Signature Date: _____

**********For Office Use Only**********

Date: Dose #1	Manufacturer	Lot #	Exp Date	VIS/EUA Date	Dose	Site	Adm By	IRIS date/initial
	Moderna	011J20A	5-11-2021	12/20/2020	0.5 ml	R L Deltoid		

Crawford County
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COVID-19 Vaccine Consent

Dose #2 Screening

Has any of your contact information on page 1 changed?	☐ Yes	☐ No	☐ Don't Know
Are you feeling sick today?	☐ Yes	☐ No	☐ Don't Know
Have you received a COVID-19 vaccine previously? If yes: Date 1st Dose: _____Date 2nd Dose: _____ If yes: Which vaccine? ☐ Pfizer ☐ Moderna ☐ Other:	☐ Yes	☐ No	☐ Don't Know
Have you ever had a severe allergic reaction (anaphylaxis) that required treatment with epinephrine or EpiPen or required hospitalization?	☐ Yes	☐ No	☐ Don't Know
Was this severe allergic reaction after receiving a COVID-19 vaccine?	☐ Yes	☐ No	☐ Don't Know
Was this severe allergic reaction after receiving another vaccine or injectable medication?	☐ Yes	☐ No	☐ Don't Know
Have you received antibody therapy (such as convalescent plasma) as treatment for COVID-19?	☐ Yes	☐ No	☐ Don't Know
Have you received another vaccine in the last 14 days?	☐ Yes	☐ No	☐ Don't Know
Have you tested positive for COVID-19? If yes: Date	☐ Yes	☐ No	☐ Don't Know
Do you have a weakened immune system (such as HIV or cancer) or do you take immuno-suppressive drugs or therapies?	☐ Yes	☐ No	☐ Don't Know
Do you have a bleeding disorder or are you taking a blood thinner?	☐ Yes	☐ No	☐ Don't Know
Are you pregnant or breastfeeding?	☐ Yes	☐ No	☐ Don't Know

By signing the consent, I acknowledge that I understand the following:

- The FDA has authorized the emergency use of the Moderna COVID-19 Vaccine that may prevent COVID-19. This vaccine is not FDA-approved. There is no FDA-approved vaccine to prevent COVID-19. The FDA has authorized the emergency use of this vaccine for individuals age 18 and older.
- V-safe is a smart-phone based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after receiving the vaccine. I understand that participation with V-safe is voluntary and that I must enroll myself.
- This vaccine is a 2-dose series and I must receive both doses in order to achieve the best immunity. I need to make sure that I receive that second dose as close to 28 days after my first dose as possible.

Vaccination Release

I have read or have had explained to me the information on the Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS). I have had a chance to ask questions that were answered to my satisfaction. I consent to the vaccine be given to me or to the person for whom I am authorized to make this request. I will not hold Crawford County Board of Supervisors, Crawford County Board of Health, or Crawford County Home Health, Hospice & Public Health agency or staff responsible for any reaction or adverse effects of this vaccine.

Printed name: _____ Signature: Typed Signature Date: _____

**********For Office Use Only**********

Date: Dose #2	Manufacturer	Lot #	Exp Date	VIS/EUA Date	Dose	Site	Adm By	IRIS date/initial
	Moderna	011J20A	5-11-2021	12/20/2020	0.5 ml	R L Deltoid		