Client Registration and COVID-19 Vaccine Consent Form

Client # ____________ Date: ___________

Please Print:

Recipient's Legal Name: ____
Last *First* *Middle*

MUST BE AT LEAST 18

Recipient Birth Date: _______ / ______ / ________ AGE ______
Month / Day / Year

Maiden/Other Name Used: ______________________

Recipient's Gender: ☐ Male ☐ Female Race/Ethnicity: ☐ Native Amer. ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other

Address: ____
Street *City* *Zip*

Primary Telephone: (_______) __________________

County of Residence: ☐ Muskegon ☐ Other: _____________

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 questions, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked.
If a question if 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? • If yes, what was the date and which vaccine product? Date: _________________ ☐ BioNTech (Pfizer) ☐ Janssen (J&J) ☐ Moderna ☐ Another Product_________________			
3. Have you ever had an allergic reaction to			
• A component of a COVID-19 vaccine or a previous dose of COVID-19 vaccine			
• A vaccine or injectable therapy that contains multiple components.			
4. Have you ever had an allergic reaction to another vaccine or an injectable medication?			
5. Have you ever had a severe allergic reaction to something other than a vaccine or injectable medication? This would include food, pet, venom, environmental or oral medication allergies?			
6. Have you received any vaccinations in the past 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 as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as cancer, leukemia, AIDS, any other immune system problem 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?			
12. Do you have dermal fillers?			

	INITIAL
1. I authorize the public health official to administer the COVID-19 vaccination.	
2. I acknowledge that I received a copy of the EUA Fact Sheet for Recipients and Caregivers.	
3. I confirm that I have read the above Fact Sheet.	
4. I understand, when applicable, that I should receive a 2nd dose of the vaccine and will do so when scheduled.	
5. I understand that the COVID-19 vaccine is available under an emergency access mechanism called an EUA and has not undergone the same type of review of FDA approved or cleared products.	

I, the undersigned, have been informed about the purpose, procedures and possible benefits and risks of receiving the vaccine. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to receive the COVID-19 vaccination.

Client/Guardian's Signature: ______________________________________ Date: ___________

Office Use Only

Vaccination Administration Information			
Manufacturer:	☐ Johnson & Johnson ☐ Moderna ☐ Pfizer ☐ Other: ____________		Time Administered:
Lot Number:		Site: ☐ L☐ R	Route:
Name (Print):			
Title:			
Signature:			