Name: ______________________________ Date of Birth: ________________ Phone: __________________

Address: ____________________________ City: _____________________ State: _______ Zip:__________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ White ☐ American Indian/Alaska Native ☐ Asian

☐ Black/African-American ☐ Native Hawaiian/Pacific Islander ☐ Other: _________________

SCREENING

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.

Are you feeling sick today? ☐ Yes ☐ No

Have you ever received a dose of COVID-19 vaccine? ☐ Yes ☐ No

If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Other: _________________

Have you ever had a severe allergic reaction to a previous vaccine or injection? ☐ Yes ☐ No

If yes, was it to a previous COVID-19 vaccination? ☐ Yes ☐ No

Have your received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? ☐ Yes ☐ No

Have you received another vaccine in the last 14 days? ☐ Yes ☐ No

If yes, type and date: ____

Have you had a positive test for COVID-19? ☐ Yes ☐ No

If yes, date of COVID-19 positivity: ______________________________

Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapy? ☐ Yes ☐ No

Do you have a bleeding disorder or are you taking a blood thinner? ☐ Yes ☐ No

Are you pregnant or breastfeeding? ☐ Yes ☐ No ☐ NA

Signature of Recipient: ____ **Date:** _____________

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Administration Only

Address verified by either ID, utility bill or proof of employment in Idaho ☐ Yes ☐ No

Signature: ____ Date: _______________

CONSENT/ DECLINATION FOR COVID-19 VACCINE

I have been offered the COVID-19 Vaccine.

- I recognize that the vaccine is experimental and has been authorized for emergency use only by the FDA. It is not an FDA-approved vaccine.
- I am aware that I have a right to decline to receive this vaccine.
- I have had the opportunity to review the "COVID-19 Vaccine EUA Fact Sheet for Recipients". (www.cvdvaccine.com)
- I am aware that there is no guarantee that administration of the vaccine will prevent my becoming infected with the COVID-19 virus. I understand that to be effective a second dose is required.
- I acknowledge that there are risks and potential side effects from the vaccine some of which are unknown. Among the reported side effects of the vaccine are:
  - Injection Site Pain
  - Chills
  - Fever
  - Tiredness
  - Joint Pain
  - Injection Site Swelling
  - Headache
  - Feeling Unwell
  - Injection Site Redness
  - Muscle Pain
  - Swollen Lymph Nodes
  - Nausea
- I understand that I may have an allergic reaction to the vaccine.
- I understand that I may consult a physician of my own choosing for advice on receiving the vaccine.
- I have asked all questions at this time and they were answered to my satisfaction.
- I have been provided the information regarding the 'V-Safe' health tracking tool and I understand it is a voluntary resource.

I have read this consent form and have been provided the "COVID-19 Vaccine EUA Fact Sheet for Recipients".

☐ **YES**, I wish to receive the COVID-19 Vaccine.

☐ **NO,** I do not wish to receive the COVID-19 Vaccine.

Printed Name of Recipient: ______________________________ Date of Birth: ____________________

Signature of Recipient: ______________________________ Date: ____________________

COVID-19 Vaccine given IM in ☐ RIGHT or ☐ LEFT deltoid on _____ /_____ /_____ Vaccine Dose# ☐ 1 or ☐ 2

Administered by: ______________________________ Title: ____________

Brand & Lot Number of Vaccine Administered

BRAND	TEMPERATURE	LOT NUMBER	EXPIRATION DATE
☐ **Pfizer**			
☐ **Moderna**			

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