The Christ Hospital™ Health Network

COVID-19 Vaccine Consent Form

Name _____

Date of Birth _____/_____/_____
Month Day Year

The following questions will help us determine if there is any reason we should not give you the COVID-19 vaccination today. ***You may choose not to answer the questions below. However, if you do not answer the questions below you will not be able to receive the vaccination at this time.***

If you answer "yes" to any question 1 through 6 below, you will not be able to be vaccinated today.

	Yes	No
1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?		
2. Are you currently under quarantine because you have had contact with someone who has tested positive for COVID-19?		
3. Are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat nausea, vomiting or diarrhea?		
4. Have you received another vaccine in the past 14 days?		
5. Have you received an antibody infusion for the treatment of COVID-19 in the past 90 days?		
6. Have you had a severe (anaphylaxis) reaction to another vaccine?		

If you answer "yes" to question 7 below, it is recommended that you have spoken to your provider before receiving the vaccine.

	Yes	No
7. Do you carry an Epipen due to severe allergic reactions from things such as food or bee stings?		

FOR WOMEN: There is currently no data regarding COVID-19 vaccination in pregnancy. The American College of Gynecology and the Society for Maternal-Fetal Medicine recommend that the SARS-CoV-2 vaccine should not be withheld from pregnant and lactating individuals. If you are pregnant, lactating or trying to conceive please discuss vaccination with your provider prior to being vaccinated.

I acknowledge that I have been provided with the Vaccine Information Sheet(s) or EUA Patient Fact Sheet(s) for the vaccine I am receiving today. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the presence of medical staff at The Christ Hospital for 15 minutes after receiving my vaccine to be monitored for any adverse effects.

I understand that my vaccine information will be maintained in The Christ Hospital's Epic System and that The Christ Hospital may be required to or may disclose information related to the administration of this vaccine to state, federal or regional registries or for purposes of treatment, payment or other health care operations (such as administration, quality assurance, or infection control).

Patient Signature_____Date:_____