Single Dose

PRAIRIE LAKES HEALTHCARE SYSTEM
CONSENT FOR COVID-19 VACCINE

Legal Name: (print): ____

Date of Birth: ________________________________ **Gender:** (circle) Male Female Unknown

I have read the information provided on the vaccine. I have had an opportunity to ask any questions that I may have regarding the vaccine.

Signature: _______________________________________ **Date:** __________________________

Home Address: ____

Phone: ____

Race: _________________________ **Ethnicity:** Non Hispanic _________ Hispanic __________

PLEASE ANSWER THESE QUESTIONS:

1. Are you under the age of 18? -- **YES** **NO**
2. Are you sick today? -- **YES** **NO**
3. Have you been diagnosed with COVID in the last 10 days and are currently on isolation? ------- **YES** **NO**
4. Have you received monoclonal antibodies or convalescent plasma in the last 90 days for the treatment of COVID-19?--- **YES** **NO**
5. Do you have HIV, other immunocompromising conditions or take immunosuppressive medication or therapies? -- **YES** **NO**
   a. If yes, have you discussed and received counseling re COVID-19 vaccination from your Physician? ---- YES NO
6. Do you have an allergy to a component of the vaccine? (Refer to the EUA Fact Sheet) ---------- **YES** **NO**
7. Have you had a serious allergic reaction or anaphylaxis to a prior vaccine or other injected medicine (intravenous, subcutaneous, or intramuscular)? --------------------------------- **YES** **NO**
8. Are you pregnant or breastfeeding? --- **YES** **NO**
   a. If yes, have you discussed and received counseling re COVID-19 vaccination from your Physician? -- YES NO
9. Have you received any other vaccine in the last 14 days or intend to receive another vaccine in the next 14 days? **YES** **NO**

Right Deltoid: ______ Left Deltoid: _____ Manufacturer:

Time: ____________ Lot Number:

Dose:

_______________________________________ __________________________

Signature of staff administering Date

Staff Initials of SDIIS entry: _________________