SAN BERNARDINO COUNTY | COVID-19 Response

COVID-19 VACCINE ADULT CONSENT FORM FOR INDIVIDUALS AGED 18 AND OLDER

Section 1 – Patient Information (please print):		
Last Name	*First Name*	*Middle Name*
Date of Birth (MM/DD/YYYY)	*Age*	*Phone Number*
Street Address, City, State, Zip Code		*Email*
Mother's Maiden Name (Maiden Last Name, First Name)		

Gender: (Check one)	*Race: (Check one)*		
☐ Female ☐ Male	☐ American Indian	☐ Alaska Native	☐ Asian
☐ Nonbinary	☐ Native Hawaiian	☐ Other Pacific Islander	☐ Black or African American
☐ Decline to Answer	☐ White	☐ Other_____	☐ Decline to Answer

Section 2 – Screening Questions	YES	NO	DON'T KNOW
1. Are you feeling sick today? (i.e. fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headaches, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea)	☐	☐	☐
2. In the past 10 days, have you tested positive for COVID-19 infection or is he/she currently being monitored for COVID-19 infection (e.g. in quarantine)?	☐	☐	☐
3. Have you had an allergic reaction to a component of a COVID-19 vaccine, including:			
• Polyethylene glycol (PEG), which is found in some medications such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
• Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
4. Have you ever had an allergic reaction to another vaccine or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐

5. Check all that apply to you:

☐ Female between ages 18 and 49 years old
☐ Male between ages 12 and 39 years old
☐ Have a history of myocarditis or pericarditis
☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet venom, environmental or oral medication allergies
☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
☐ Have a history of thrombosis with thrombocytopenia (TTS) following an adenovirus-vectored vaccine (e.g. Johnson & Johnson, Astrazeneca or Sputnik COVID-19 vaccines)
☐ Have a bleeding disorder
☐ Take a blood thinner
☐ Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
☐ Has a history of heparin-induced thrombocytopenia (HIT)
☐ Is currently pregnant or breastfeeding
☐ Have received dermal fillers
☐ History of Guillain-Barré Syndrome (GBS)
☐ Have received the COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies

Note: Please continue to page 2.

FOR OFFICE USE ONLY – SARS CoV-2 VACCINATION RECORD	
Vaccine Formulation: ☐ Bivalent Grey Cap (12 years and older) ☐ Bivalent Dark Blue Cap (6 years and older)	Date Administered:
Manufacturer: ☐ Pfizer-BioNTech ☐ Moderna	Dose: _____mL Route: **Intramuscular (IM)**
Lot #:	Site: ☐ Left Deltoid ☐ Right Deltoid
Expiration Date:	Vaccine Administered By
EUA Fact Sheet or VIS Given: ☐ Yes ☐ No	Name (please print): Signature:
VIS Date:	Title: ☐ RN ☐ LVN ☐ Pharmacist ☐ _____

Section 3 – Consent

- I have been given a copy and have read the Emergency Use Authorization (EUA) and reviewed the FDA Fact Sheet for Recipients and Caregivers for the COVID-19 vaccine product. I will be administered (check one):

	VACCINE PRODUCT	AUTHORIZED AGE GROUP	FACT SHEET
☐	**Pfizer-BioNTech COVID-19 Vaccine, Bivalent**	**6 months of age and older**	
☐	**Moderna COVID-19 Vaccine, Bivalent**	**6 months of age and older**	

- I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine indicated and ask that it be given to me.
- I understand that all vaccines have risks and side effects; and that there may be risks that are not known yet.
- As required by state law (Health and Safety Code, § 120440), all immunizations will be reported to the California Immunization Registry (CAIR2). I understand the information in the child's CAIR2 record will be shared with the local health department and State Department of Public Health, shall be treated as confidential medical information, and shall be used only to share with each other or as allowed by law. I may refuse to allow the information to be further shared and can request the CAIR2 record be locked by visiting the Request to Lock My CAIR Record.
- By signing this form, I give San Bernardino County and participating vaccination partner's permission to contact me regarding COVID-19 vaccine reminders and access to electronic vaccination records.
- I will not have to pay for either the COVID-19 vaccine or the cost of administering the vaccine. If I have health insurance, I understand that my insurance company may be billed for the costs of administering the vaccine.

☐ **By checking the box, I give consent to be vaccinated with the COVID-19 vaccine indicated in Section 3 and understand that I am receiving the vaccine voluntarily.** I release County of San Bernardino, its employees, and representatives from any liability or further responsibility with regard to receiving the vaccine.

Signature	*Date*

I certify that I am the patient's legal representative and/or legal conservator and I am authorized by the patient or other legal authorities to sign and accept the listed terms on the patient's behalf.

Signature of Legal Guardian (Medical Power of Attorney)	*Date*

Legal Guardian printed name

Digital Vaccine Record Portal