



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)
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Nonbinary <input type="checkbox"/> Decline to Answer	<input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> 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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you had an allergic reaction to a component of a COVID-19 vaccine, including: <ul style="list-style-type: none"> • 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 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Check all that apply to you:

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

Note: Please continue to page 2 for Section 4.

FOR OFFICE USE ONLY – SARS CoV-2 VACCINATION RECORD

COVID-19 Vaccine: <input type="checkbox"/> Dose 1 <input type="checkbox"/> Dose 2 <input type="checkbox"/> Dose 3 <input type="checkbox"/> Dose 4 <input type="checkbox"/> Dose 5	Date Administered:
Manufacturer:	Dose: _____ mL Route: Intramuscular (IM)
Lot #:	Site: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid
Expiration Date:	Vaccine Administered By
EUA Fact Sheet or VIS Given: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name (please print):
VIS Date:	Signature:
	Title: <input type="checkbox"/> RN <input type="checkbox"/> LVN <input type="checkbox"/> Pharmacist _____

Section 4 – 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	PRIMARY SERIES	INTERVAL
<input type="checkbox"/>	Moderna (Spikevax) COVID-19 Vaccine	18 years of age and older	2 doses*	28 days
<input type="checkbox"/>	Pfizer-BioNTech (Comirnaty) COVID-19 vaccine	12 years of age and older	2 doses*	21 days
<input type="checkbox"/>	Janssen (Johnson & Johnson) COVID-19 vaccine	18 years of age and older	1 dose*	N/A

**After completion of the primary series, individuals may be eligible for a booster or an additional dose*

- 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.
- My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine.
- Those with previous anaphylactic reactions or other risk factors should stay for 30 minutes.
- 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 4 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.

<i>Signature</i>	<i>Date</i>
------------------	-------------

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.

<i>Signature of Legal Guardian (Medical Power of Attorney)</i>	<i>Date</i>
----------------------------------------------------------------	-------------

Legal Guardian printed name

**Moderna (Spikevax)
EUA Fact Sheet**



**Pfizer (Comirnaty)
EUA Fact Sheet**



**Janssen (J&J)
EUA Fact Sheet**

