



# 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:			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Polyethylene glycol (PEG), which is found in some medications such as laxatives and preparations for colonoscopy procedures			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• A previous dose of COVID-19 vaccine			<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"/> Have a bleeding disorder			
<input type="checkbox"/> Male between ages 12 and 39 years old		<input type="checkbox"/> Take a blood thinner			
<input type="checkbox"/> Have a history of myocarditis or pericarditis		<input type="checkbox"/> Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies			
<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"/> Has a history of heparin-induced thrombocytopenia (HIT)			
<input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum		<input type="checkbox"/> Is currently pregnant or breastfeeding			
<input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection		<input type="checkbox"/> Have received dermal fillers			
<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"/> History of Guillain-Barré Syndrome (GBS)			
		<input type="checkbox"/> Have received the COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies			
<b>Note: Please continue to page 2.</b>					

FOR OFFICE USE ONLY – SARS CoV-2 VACCINATION RECORD	
COVID-19 Vaccine: Primary Series: <input type="checkbox"/> Dose 1 <input type="checkbox"/> Dose 2 <input type="checkbox"/> Dose 3 Bivalent Booster: <input type="checkbox"/> Dose 1	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 <input type="checkbox"/> _____

**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	DOSES	INTERVAL
<input type="checkbox"/>	Moderna (Spikevax) COVID-19 Vaccine	12 years of age and older	2 doses*	4-8 weeks
<input type="checkbox"/>	Pfizer-BioNTech (Comirnaty) COVID-19 vaccine	12 years of age and older	2 doses*	3-8 weeks
<input type="checkbox"/>	Janssen (Johnson & Johnson) COVID-19 vaccine	18 years of age and older	1 dose*	N/A
<input type="checkbox"/>	Novavax COVID-19 vaccine	12 years of age and older	2 doses*	3-8 weeks
<input type="checkbox"/>	Pfizer-BioNTech COVID-19 Vaccine, <u>Bivalent Booster</u>	12 years of age and older	1 dose	At least 2 months
<input type="checkbox"/>	Moderna COVID-19 Vaccine, <u>Bivalent Booster</u>	18 years of age and older	1 dose	At least 2 months

*\*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.

Signature	Date
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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
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Legal Guardian printed name

**Moderna (Spikevax)  
EUA Fact Sheet**



**Pfizer (Comirnaty)  
EUA Fact Sheet**



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



**Novavax  
EUA Fact Sheet**

