COVID 19 VACCINATION ACCEPTANCE/DECLINATION

First: _____ Last:_____ Sex: M F DOB: _____

Address:_____ City:_____ ZIP: _____

Vaccine Schedule Phase/Tier (Clinic use only)

I WANT TO RECEIVE THE COVID 19 VACCINE TODAY.

- I am 18 or older.
- I have not experienced anaphylaxis (difficulty breathing) or severe allergic reactions from a previous vaccination or an injectable medication.
- I have not had any other vaccinations in the previous 14 days (e.g. MMR, Shingrix, Varicella).
- I am not currently sick with a fever, active respiratory infection or other moderate/severe illness.
- I am not allergic to the ingredients in the COVID-19 vaccine:
- I have not received monoclonal antibodies or convalescent plasma for treatment of COVID-19 within the past ninety (90) days.
- I am not pregnant, attempting to become pregnant or breastfeeding.
- I do not have a bleeding disorder or are on a blood thinner
- I am not immunocompromised or are taking a medication that affects the immune system (such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; HIV/AIDS, cancer, leukemia, ankylosing spondylitis or radiation treatments).
- **I agree to WAIT near the clinic location for 15 minutes** after receiving the vaccine. If I have previously had a severe allergic reaction to a vaccine or injectable medication, I agree to WAIT near the clinic location for 30 minutes after receiving the vaccine.
- **I understand that the COVID-19 vaccine is a two-part vaccine series. By signing this consent, I am agreeing that I will receive the first and second part of the vaccine series.**
- I understand that the common risks associated with the COVID-19 vaccine include but are not limited to pain, redness or swelling at the site of injection, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, feeling unwell or swollen lymph nodes (lymphadenopathy). I understand that the vaccine may cause a severe allergic reaction which can include anaphylaxis (difficulty breathing, swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness). I understand that these may not be all the side effects of the COVID-19 vaccine as the vaccine is still being studied in clinical trials. I also understand that it is not possible to predict all possible side effects or complications which could be associated with the vaccine. I understand that the long-term side effects or complications of this vaccine are not known at this time.
- All vaccines are documented in the CAIR immunization database. Information is available.

Knowing that this is a vaccine that is approved for emergency use by the FDA, I chose to accept the vaccine.

Signed: _____ Date: _____