ConvenientMD
URGENT CARE

Consent Form for Administration

COVID-19 Vaccination

Patient Name:________________________________ Date of Birth: _____________ Temperature _____________

Screening Questions (if you answer yes, please explain below) — Please circle

1. Are you sick today? *(If yes do not vaccinate)* — Yes No
2. Have you had any symptoms of COVID-19 including fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches? *(If yes do not vaccinate)* — Yes No
3. Have you ever had a serious reaction after receiving a vaccination including anaphylaxis? *(If yes you may want to discuss with your PCP first, will need to monitor for 30 minutes post vaccination* — Yes No
4. Have you had Guilliain Barre Syndrome? *(If yes, should consult with primary care provider prior to vaccination)* — Yes No
5. Are you pregnant/breastfeeding or is there a chance you could become pregnant? *(If yes, should consult with obstetrician prior to vaccination)* — Yes No
6. Have you received any vaccinations in the past 4 weeks? *(okay to administer within 4 weeks of other vaccinations or same day as other vaccinations aside from alternative COVID-19 vaccines)* — Yes No
7. In the past two weeks, have you tested positive for COVID-19? (*should be fully recovered prior to receiving vaccine)* — Yes No
8. Do you have any allergies or reactions to any food, medications, vaccines or latex? *(If yes you may want to consult your PCP first, will need to monitor for 30 minutes post* vaccination) — Yes No
9. Are you immunocompromised or on a medication that affects your immune system? *If yes, you may want to discuss with your PCP prior to vaccination.* — Yes No

Within the last 90 days have you experienced an immune condition causing both clotting and low platelets? (@ *do not administer the Janssen Vaccine)* — Yes No

11. Have you received a previous dose of anyCOVID-19 vaccinations? — Yes No
12. Have you received monoclonal antibodies in the last 90 days? *(if yes, do not vaccinate)* — Yes No

If you answered "Yes" to any of the foregoing questions, please explain:

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I hereby acknowledge the following: (please initial)

______I have been provided with a copy of, and reviewed the contents of, the attached Vaccine Information Sheet (VIS) or Emergency Use Authorization (EUA)

_____ Known potential adverse reactions to the Vaccine include each of the potential adverse reactions identified in the VIS or EUA provided to me.

______There may be additional adverse reactions to the Vaccine that are not identified in the VIS or EUA provided to me.

_______ I have had the opportunity to ask questions concerning the Vaccine, the administration of the Vaccine and potential adverse health consequences of receiving the Vaccine, and all of my questions have been answered to my satisfaction.

Consent and waiver: I consent to the administration of the Vaccine by ConvenientMD. I fully release and discharge ConvenientMD, its affiliates and their officers, directors, employees and persons acting on their behalf or at their direction from any liability or claim related to the administration of, or my receipt of, the Vaccine.

Signature of Patient:____Date: ____________________

To Be Completed by Person Administering:

Vaccine: ____________________ VIS/EUA Date: __________ Lot #: ________________ Exp Date:__________ Site: _____

Administered by: ______________________________ Title:__________________ Date Given: __________ Time Given: __________

For Mobile Vaccine Initiative:

Address:____________________________ **County:** ___________ **State:**___ **Zip:**___________ **Race:**___________ **Ethnicity:** _____________