COVID-19 VACCINE CONSENT FORM

WHITMAN-WALKER HEALTH
we see you.

SECTION A: PATIENT INFORMATION

Last name: _____ First name: _____ M.I.: _____

Date of birth (MM/DD/YYYY): _____/ _____/_____ Age:_____

Home address: _____ City:_____ State:_____ Zip:_____

Email address: _____ Phone:_____

SECTION B: SCREENING CHECKLIST

If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.
It just means additional questions may be asked.

	SCREENING QUESTIONS	YES	NO	DON'T KNOW
1	Are you sick today, with a fever, respiratory infection, or other moderate/severe illness?	◯	◯	◯
2	Have you had any vaccinations in the previous 14 days?	◯	◯	◯
3	Have you received monoclonal antibodies or plasma for treatment of COVID-19 within the past 90 days?	◯	◯	◯
4	Do you have ANY allergies (for example, to food or medication)? **If yes, please list:**	◯	◯	◯
5	Have you ever had a serious reaction or fainted after receiving a vaccination or injectable medication?	◯	◯	◯
6	Do you have a sensitivity to latex (gloves, bandages)?	◯	◯	◯
7	Do you have a bleeding disorder, or are you on a blood thinner?	◯	◯	◯
8	Are you pregnant, attempting to become pregnant, or breastfeeding?	◯	◯	◯
9	Are you immunocompromised or are you taking medicine that weakens or affects your immune system?	◯	◯	◯
10	Have you ever had a seizure or brain disorder or other nervous system problem?	◯	◯	◯

You should not get the COVID-19 vaccine if you:
- **had a severe allergic reaction after a previous dose of this vaccine**
- **had a severe allergic reaction to any ingredient of this vaccine.**

Form Completed By (Print Name): _____ Date:_____

Form Reviewed By (Print Name): _____ Date: _____

SECTION C: COVID-19 VACCINE INFORMED CONSENT

By my signature below, I indicate my understanding and agreement to the following:

- I have voluntarily chosen to receive COVID-19 vaccination.
- I agree the answers I have provided to the screening questions above and to my vaccination provider are accurate.
- I have read or have had explained to me and understand "What To Do If You Have A Reaction To The COVID-19 Vaccination" and FDA Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine.
- I understand common risks associated with the COVID-19 vaccine include but are not limited to pain, redness or swelling at the injection site, tiredness, headache, muscle pain, chills, joint pain, fever, feeling unwell, or swollen lymph nodes. I understand the vaccine may cause a severe allergic reaction which can include difficulty breathing, swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness. I understand these may not be all the side effects of the COVID-19 vaccine, and it is not possible to predict all possible complications which could be associated with the vaccine.
- I have been offered and/or provided a copy of Whitman-Walker Health's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
- I understand and agree that Whitman-Walker Health is required to submit COVID-19 vaccine administration data to the District of Columbia Immunization Information System and to report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS).

- **I agree to WAIT at the clinic waiting area for 15 minutes for observation after receiving the vaccine. If I have previously had a severe allergic reaction to a vaccine, I agree to WAIT for 30 minutes after receiving the vaccine.**
- **I consent to the administration of the COVID-19 vaccine by staff of Whitman-Walker Health, and on behalf of myself, my heirs and personal representatives, I release and hold harmless Whitman-Walker Clinic, Inc. d/b/a Whitman-Walker Health, its agents, employees, officers, directors and affiliates from all liability or claims whether known or unknown, including acts of omission or commission, resulting from, arising out of, or in any way related to my receipt of this vaccination.**

Signature of person receiving vaccine: _____

Date: _____