COVID-19 Vaccine Consent

Personal Information: **Date:**

______________________ ______________________ ________
Last Name First Name Middle Initial

______________ ________ (______) ________-__________
Date of Birth Sex Area Code Phone Number

____
Residential Address City State Zip

____
Occupation

Ethnicity ***REQUIRED***: ❑ Hispanic ❑ Non-Hispanic ❑ Unknown ❑ Declined to Answer
Race ***REQUIRED***: ❑ Asian ❑ Black ❑ Hawaiian ❑ White ❑ American Indian ❑Alaskan Native ❑Declined to Answer

Screening for Vaccine Eligibility

	YES	NO
Have you had a severe allergic reaction after receiving a previous dose of the COVID-19 vaccine?		
Have you had a severe allergic reaction to any ingredient in the COVID-19 vaccine?		

☒ The Fact Sheet for Patients and Parent/Caregiver for the COVID-19 Vaccine I am receiving has been offered to me.

☒ I have read or had explained to me the Fact Sheet for Patients and Parents/Caregivers for the COVID-19 Vaccine and I understand the risk and benefits.

☒ I understand the COVID-19 Vaccine has been approved by an emergency use authorization (EUA) process and has not fully been FDA approved.

☒ I understand the potential risks from the therapy including serious allergic reactions (anaphylaxis). Other adverse reactions that have been reported include site pain, fatigue, headache, muscle pain, chills, joint pain, fever, injection site swelling, injection site redness, nausea, malaise, and lymphadenopathy.

☒ I understand that there may be other potential options to prevent COVID-19.

☒ I was offered the opportunity to ask questions and all questions were answered.

☒ I agree to proceed with receiving the COVID-19 Vaccine.

☒ **I GIVE CONSENT** to Kern Medical Center and its staff to vaccinate my minor child with this vaccine. (If this form is not signed, then you will not be vaccinated)

☒ **I GIVE CONSENT** to Kern Medical Center to disclose any required information to California Immunization Registry (CAIR)

Signature of Parent/Legal Guardian ______________________ ______________________

Print Name ______________________________________ DATE ______________