Washington County EMS
1875 HWY 290 West
Brenham, Texas
77833 979/277-6267

# COVID-19 Vaccination Consent Form 2020-2021

| Last Name *(Please print)* | First Name | MI | Date of Birth | ☐ Male ☐ Female |
|---|---|---|---|---|
| | | | | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

| County of Residence | Phone Number | Ethnicity | Race (Please Circle One) |
|---|---|---|---|
| | | ☐ Hispanic or Latino<br>☐ Not Hispanic/Latino | White / American Indian<br>African American / Native Hawaiian<br>Alaska Native / Other____________<br>Pacific Islander / ________________ |

## SCREENING FOR VACCINATION ELIGIBILITY

| Question | | |
|---|---|---|
| 1. Are you pregnant? | Yes | No |
| 2. Are you currently breastfeeding? | Yes | No |
| 3. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to other vaccines or injectable medications/infusions? | Yes | No |
| 4. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of the vaccine, including lipid nanoparticles or polyethylene glycol (PEG)? | Yes | No |
| 5. Have you received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next 14 days? | Yes | No |
| 6. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days? | Yes | No |
| 7. Are you under age 16? | Yes | No |
| 8. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.? | Yes | No |
| 9. Have you tested positive for COVID-19 in the last 10 days? | Yes | No |
| 10. Are you currently in quarantine for COVID-19 exposure? | Yes | No |
| 11. If this is your second dose, when was the date of your first dose? | / / | |
| 12. If this is your second dose, which vaccine did you receive (Pfizer, Moderna, etc.)? | | |

## CONSENT FOR VACCINATION

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization Fact Sheet provided to me today. I understand the benefits and risks of the vaccine.

The vaccine checked above should be given to the person named above for whom I am authorized to make this request. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

Signature of Parent/Guardian/Patient______________________________________________________________Date__________________

**FOR ADMINISTRATIVE USE ONLY** **VIS Date:**

| Vaccine | Date Vaccination and EUA Given: | Route IM *R L* | Manufacturer | Lot No. | Printed Name and Signature of Vaccine Administrator |
|---|---|---|---|---|---|
| | | | | | |

## INFORMATION FOR HEALTH CARE PROFESSIONALS ABOUT VACCINATION ELIGIBILITY

1. Are you pregnant?

   **IF YES: Please ask the patient whether they discussed vaccination with a medical provider. Patients who are pregnant may choose to be vaccinated whether they discussed vaccination with a medical provider or not.**

2. Are you currently breastfeeding?

   **IF YES: Please ask the patient whether they discussed vaccination with a medical provider. Patients who are lactating may choose to be vaccinated whether they discussed vaccination with a medical provider or not.**

3. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to other vaccines or injectable medications/infusions?

   **IF YES: Please ask the patient whether they discussed vaccination with a medical provider. If they have, allow vaccination to proceed. Vaccine providers should observe patients after vaccination to monitor for the occurrence of immediate adverse reactions:**
   - **Persons with a history of anaphylaxis: 30 minutes**
   - **All other persons: 15 minutes**

4. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of the vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?

   **IF YES: Do Not Vaccinate**

5. Have you received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next 14 days?

   **IF YES: Do Not Vaccinate**

6. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?

   **IF YES: Do Not Vaccinate**

7. Are you under age 16?

   **IF YES: Do Not Vaccinate**

8. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?

   **IF YES: Have patient discuss existing symptoms with a medical provider.**

9. Have you tested positive for COVID-19 in the last 10 days?

   **IF YES: Do Not Vaccinate**

10. Are you currently in quarantine for COVID-19 exposure?

    **IF YES: Do Not Vaccinate**

11. If this is your second dose, when was the date of your first dose?

    **Do Not Vaccinate if less than 17 days ago for Pfizer, or less than 24 days ago for Moderna.**

12. If this is your second dose, which vaccine did you receive (Pfizer, Moderna, etc.)?

    **Ensure that the second dose is from the same manufacturer as the first dose.**
    **If different: Do Not Vaccinate.**