Client # _____

Southwest District Health
COVID-19 Vaccination Consent Form

Client Name: _____ Birthdate: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Age: _____ Male Female **Hispanic/Latino** Y N

Race – Circle One: White Black Native American Asian Pacific Islander Other _____

PLEASE CIRCLE YOUR ANSWERS

Is recipient feeling sick today? …….... No / Yes

Ever received a dose of COVID-19 vaccine? ……..... No / Yes / Don't know

If yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Other Product: _____

Ever have a severe allergic reaction to an injectable medication? (e.g., anaphylaxis) For example, a reaction for which treatment with

epinephrine or EpiPen was needed or for which a hospital visit was required…….. No / Yes / Don't know

Was the severe allergic reaction after receiving a COVID-19 vaccine?..... No / Yes / Don't know

Was the severe allergic reaction after receiving another vaccine or injectable medication? ….. No / Yes / Don't know

4. Any known blood disorders or currently taking a blood thinner?.....No / Yes / Don't know

Has recipient received passive antibody therapy as treatment for COVID-19?..... No / Yes / Don't know

Has recipient had a positive test for COVID 19 or has a doctor ever told you that you had COVID 19 in the last 90 days? ……. No / Yes

Date of positive test? _____/_____/_____

I have reviewed and answered the questions above, to the best of my ability. I have reviewed the Vaccine Information Fact Sheet. I have voiced my questions and concerns and am satisfied with the answers. I understand the benefits of the recommended vaccine (s). I understand that it is my responsibility to provide up to date information on medical status and that providing incorrect information can be dangerous health wise. I authorize the healthcare staff to perform the necessary health care services, today. Southwest District Health enters all immunization records into the Idaho Immunization Reminder System (IRIS). You may opt out of IRIS at any time by contacting the Idaho Immunization Program.

By signing below, you are authorizing for the COVID-19 vaccine to be administered.

Signature of Patient or Parent/Guardian: _____ Today's Date: _____

CLINIC USE ONLY COVID-19 fact sheet given? ☐ Yes ☐ Declined

Final Screener: _____ Vaccinator: _____ Vaccination Date: _____

VACCINE RECEIVED:

☐ **Pfizer Peds (Age 5-11)**	☐ **Pfizer (Ages 12+)**	☐ **Moderna**	☐ **Janssen**
☐ 1st Dose	☐ 1st Dose	☐ 1st Dose	☐ Janssen Booster
☐ 2nd Dose	☐ 2nd Dose	☐ 2nd Dose	
	☐ Pfizer Booster	☐ Moderna Booster	
	☐ 3rd Dose (Imm Comp)	☐ 3rd Dose (Imm Comp)	

Injection Location: ☐ Left Deltoid ☐ Right Deltoid

Clinic Site: ☐ Caldwell ☐ Emmett ☐ Payette ☐ Weiser ☐ Homedale ☐ Marsing

☐ Proof of address verification – DL/ID, UT Bill, Letter with Name, Voucher (employer/org/agency)

Lot Information:

Expiration date:

NOTES:_____