



# NACA

## Consent Form 2021 Covid-19 Vaccine

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### Covid-19 Vaccine

You and/or your child are being offered the COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2.

### WHO SHOULD NOT GET THE COVID-19 VACCINE(S)?

You should not get the COVID-19 Vaccine if you:

- had a severe allergic reaction after a previous dose of the vaccine
- had a severe allergic reaction to any ingredient of the vaccine.

### WHAT ARE THE RISKS OF THE COVID-19 VACCINE(S)?

There is a remote chance that the COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the COVID-19 Vaccine. For this reason, your vaccination provider asks that you stay for 15-30 minutes of monitoring after vaccination. Signs of a severe allergic reaction can include:

- Difficulty breathing
- Swelling of your face and throat
- A fast heartbeat
- A bad rash all over your body
- Dizziness and weakness

**Side effects** that have been reported with the Pfizer-BioNTech COVID-19 Vaccine include:

- severe allergic reactions
- non-severe allergic reactions such as rash, itching, hives, or swelling of the face
- tiredness
- headache
- muscle pain
- chills
- joint pain
- fever
- injection site swelling
- injection site redness
- nausea
- feeling unwell
- swollen lymph nodes (lymphadenopathy)
- diarrhea
- vomiting
- arm pain

***I have read and understood the information above and consent to receiving a Covid-19 Vaccine.***

**Patient Name:** \_\_\_\_\_ **Patient DOB:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***For Healthcare employee only***

Covid-19 Screen complete?

YES

NO

Date Vaccination and VIS given: \_\_\_\_\_ Date of VIS: \_\_\_\_\_

Location of vaccination: NACA FHC

Vaccine Manufacturer: \_\_\_\_\_

Vaccine Lot #: \_\_\_\_\_

Site of Vaccination: \_\_\_\_\_

Signature & Title of Vaccine Administrator: \_\_\_\_\_

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