Consent Form 2023 COVID-19 Vaccine

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-CoV2.

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

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

- Have had a severe allergic reaction after a previous dose of the COVID-19 vaccine.
- Have had a severe allergic reaction to any ingredient of the COVID-19 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 for monitoring after receiving your vaccine. Signs of a severe allergic reaction can include:

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

SIDE EFFECTS that have been reported with the COVID-19 vaccines and boosters 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 side redness
- Nausea
- Feeling unwell
- Swollen lymph nodes (lymphadenopathy)
- Diarrhea
- Vomiting
- Arm pain

I have read and understood the information above and consent to receive a COVID-19 vaccine.

Patient Name: _____ **Patient DOB:** _____

Patient Signature: _____ **Date:** _____

For Healthcare Employee only

COVID-19 screen complete ?

YES ☐ NO ☐

Date vaccine and VIS given: _____ Date of VIS: _____

Location of vaccination: NACA FHC

Vaccine Manufacturer: _____

Vaccine Lot #: _____

Site of vaccination: _____

Signature & Title of Vaccine Administrator: _____