

COVID-19 Vaccine Consent



Cedar County Public Health

PATIENT INFORMATION			
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	GENDER (circle one): Male Female Other
DATE OF BIRTH: ____/____/____	AGE:	PHONE NUMBER:	
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:
YOUR PHYSICIAN'S NAME:		YOUR EMPLOYER:	YOUR ROLE:

PLEASE ANSWER ALL QUESTIONS	CIRCLE ONE	
1. Have you received a dose of COVID-19 vaccine from a provider other than Cedar Co. Public Health? If yes, was it Moderna?	YES	NO
2. Are you sick today? (For example: a cold, fever, or acute illness)	YES	NO
3. Are you allergic to any foods, medications, vaccines, or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.)	YES	NO
4. Have you ever had severe allergic reaction (anaphylaxis) requiring epinephrine, or for which you went to the hospital?	YES	NO
5. Have you ever had Guillain-Barre Syndrome? (a type of temporary severe muscle weakness)	YES	NO
6. Does your provider consider you immunocompromised, or do you take medication that affects your immune system?	YES	NO
7. Do you have a bleeding disorder or are you taking a blood thinner?	YES	NO
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	YES	NO
9. Have you received a vaccine within the past 14 days, or do you plan to receive a vaccine within the next 14 days?	YES	NO
10. Are you pregnant, or do you plan to become pregnant, in the next 28 days?	YES	NO
11. Are currently breastfeeding, or do you plan to start breastfeeding, in the next 28 days?	YES	NO
12. In the past 14 days have you been diagnosed with COVID-19 or been in close contact with someone with COVID-19?	YES	NO
Dose #2 ONLY: Have there been any changes to your responses to the questions listed above?	<input style="width: 40px; height: 20px;" type="checkbox"/>	YES NO
If yes, describe: _____ Please initial at second appointment		

CONSENT FOR VACCINATION	
<ul style="list-style-type: none"> The Vaccine Information Sheet, or the Emergency use Authorization fact sheet have been made available to me and I understand the risks & benefits. I understand that this vaccine is not approved by the FDA, but is being offered under an FDA issued emergency use authorization. I give consent to Cedar County Public Health to vaccinate the person named above and to record the vaccination in the Iowa Immunization Registry Information System (IRIS). I certify that the information I provided for payment is correct. I authorize release of all records required to act on this request. I authorize Medicare, Medicaid, Blue Cross Blue Shield, or other insurance to make payments directly to Cedar County Public Health. 	
Patient Signature: X _____	Date: _____

INSURANCE	INSURANCE COMPANY NAME: _____		<input type="radio"/> UNINSURED
	IDENTIFICATION NUMBER: _____		
	NAME OF CARD HOLDER: _____		BIRTH DATE OF CARD HOLDER: _____/_____/_____

FOR OFFICE USE ONLY			FOR OFFICE USE ONLY		
<input type="radio"/> I have screened this patient for contraindications		LOT #:	<input type="radio"/> I have screened this patient for contraindications		LOT #:
<input type="radio"/> Left arm	<input type="radio"/> Right arm		<input type="radio"/> Left arm	<input type="radio"/> Right arm	
Nurse's Signature: _____		Date: _____	Nurse's Signature: _____		Date: _____
DOSE 1- IRIS	DOSE 1- NN	DOSE 1-BILLED	DOSE 2- IRIS	DOSE 2- NN	DOSE 2-BILLED