First District Health Unit COVID-19 Vaccine Consent Form

PLEASE PRINT. Use full, legal name.

FIRST NAME_____ **M.I.** _____ **LAST NAME**_____

DATE OF BIRTH _____

Answer health questions for person getting COVID-19 vaccination

Y____N____ Are you feeling sick today?

Y____N____ Have you ever received a dose of COVID-19 vaccine?

Y____N____ Have you received any other vaccines in the past 14 days?

Y____N____ Have you ever had a **severe** allergic reaction (anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?

Y____N____ was the severe allergic reaction after receiving a COVID-19 vaccine?

What was your severe allergic reaction to? _____

Y____N____ Have you received monoclonal antibodies or convalescent plasma for COVID-19 treatment in past 90 days?

Y____N____ Have you tested positive for COVID-19 in the past 10 days?

Y ___ N____ Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?

Y____N____ Do you have a bleeding disorder or are on a blood thinner?

Y____N____ Are you pregnant or breastfeeding?

Y____N____ Do you have dermal fillers?

ONLY SIGN IF ASKED BY STAFF TO SIGN.

I have viewed the Factsheet provided. I have read the information about the vaccine. I had an opportunity to ask questions and believe that I understand the benefits and risks of the vaccine. **I consent to the administration of the vaccine(s) listed to be given to the person named above & am authorized to give consent.** FDHU **Notice of Privacy Practices** is available online or by request. I assign and **authorize any third-party payer/insurer** to make direct payment to FDHU. I will not be responsible for charges not covered by 3rd party payer. I authorize the release of information necessary to process this claim. Info will be shared with the ND Immunization Info System.

SIGNATURE OF CLIENT OR PERSON AUTHORIZED TO CONSENT ON THE CLIENT'S BEHALF TO RECEIVE VACCINATION:

X_____**DATE:**_____

FOR FDHU STAFF USE ONLY				
Lot #	Site LA RA	☐ 1st Dose ☐ 2nd Dose	Vaccine Administrator Initials	Date
SAVE PAPER CONSENT	Demo	Note done/sent	ESB ✓	Revised 4/29/2021