MHSF Health Centers

COVID-19 VACCINATION ADMINISTRATION RECORD/CONSENT

First Name: _____ Last Name: _____DOB: _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.

If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Covid-19 Vaccine:	**YES**	**NO**
1. Do you feel sick today?		
2. Have you ever received a dose of COVID-19 vaccine? If Yes Which? Pfizer Moderna Other		
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)		
a. A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures		
b. Polysorbate		
c. A previous dose of COVID-19 vaccine		
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)		
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.		
6. Have you received any vaccine in the last 14 days?		
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?		
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
10. Do you have a bleeding disorder or are you taking a blood thinner?		
11. Are you pregnant or breastfeeding?		

If YES to any of the above, please give additional information: _____

_____

_____

It is important that you, as the patient or patient's legally authorized representative(s), understand and acknowledge the following, with regard to administration of the COVID-19 vaccine offered by Methodist Health System Foundation:

The SARS-CoV-2 virus ("COVID-19") has caused an unprecedented modern global pandemic that has mobilized scientists and drug manufacturers to work to create safe and effective vaccines to get the crisis under control. No vaccine is released in the United States without undergoing rigorous, multi-layered testing and approval by the Food and Drug Administration. During a public health emergency, however, vaccines can be released for patient administration by the FDA prior to completion of multi-phase clinical trials and approval. This is done by the FDA's granting of Emergency Use Authorization ("EUA") when the vaccine meets reasonable thresholds for safety and effectiveness and people are in urgent need of care. Under an EUA, the FDA has found that known potential benefits outweigh its known and potential risks. The vaccine for which you are presenting to Methodist Health System Foundation has been released under an EUA, which Methodist Health System Foundation is honoring in its distribution of the vaccine to the public. While the FDA's authorization indicates its belief that usage is recommended over possible risks, there is still the possibility that unknown risks of the vaccine could exists. By signing this document, you acknowledge and assume these risks. Further, you waive any and all claims of liability against and hold harmless any Methodist Health Foundation entity or provider for any harm caused to you by said possible unknown risks of the vaccine.

Patient Signature: _____ Date: _____

FOR HEALTH CARE PROVIDER ONLY

Immunizer Initials: _____ Date of Admin: _____ Site: _____ Lot: _____ Exp Date: _____

Vaccine Administered (Circle One): Pfizer or Moderna

(Rev: 05/2021)