UnityPoint Clinic
Methodist In School Health

CONSENT TO VACCINATION

Name: _____ Birth Date: _____ School: _____

Address_____City_____Zip_____

Parent/Guardian _____Birth Date:_____ Phone_____

Physician: _____

List of allergies to medications/foods or other: _____

_____

Have you had COVID-19 in the past 90 days:
YES_____ NO_____

Patient, family member, or legal guardian received the Emergency Use Authorization (EUA) and/or the Vaccination Information Statement (VIS) and stated understanding of their contents prior to vaccine administration? YES_____NO_____

Have you received antibody therapy for the treatment of COVID-19 in the past 90 days? (IF YES—this vaccination should be deferred for at least 90 days after the treatment). YES_____NO_____

Have you received any other vaccinations in the past 14 days? YES_____NO_____

Have you received convalescent plasma as treatment for COVID-19 in the past 90 days? (IF YES—this vaccination should be deferred for at least 90 days after the treatment). YES_____NO_____

Have you received the COVID-19 vaccine in the past year: YES _____ No_____; if yes, which manufacturer:

_____ Date: _____

Have you had a serious (e.g. ANAPHYLAXIS) or immediate reaction of any severity to a previous dose of COVID vaccination or any of its components? YES_____NO_____ What was the reaction? _____

_____
_____

Have you ever had a serious allergic reaction (ANAPHYLAXIS) to any other vaccine or injectable therapy in the past? (IF YES, an observation period of 30 minutes is recommended after receiving the vaccination). YES_____NO_____ What was the reaction?

_____
_____

By signing this consent, I _____, acknowledge that I have read and answered all questions truthfully. Furthermore, by signing this consent, I am acknowledging that I have received the EUA and or the VIS regarding the COVID-19 vaccination to be received, have had all questions answered, and I am agreeing to the administration of the COVID-19 vaccination.

Patient Name (PRINT): _____

Parent/Legal Guardian name (PRINT): _____Date: _____

Patient/Parent/Legal Guardian signature: _____

Relationship to the patient: _____