Helping Others with comPassion and Empathy – H.O.P.E.

COVID-19 VACCINATION INFORMED CONSENT

LAST NAME_____FIRST NAME: _____
DATE_____DATE OF BIRTH _____PHONE NUMBER_____
ADDRESS_____ CITY_____ STATE_____ ZIP_____

Information collected on this form will be used to document authorization for receipt of vaccines, administration of vaccine, and billing insurance if applicable. Information will be shared with Wisconsin Immunization Registry as well as all reported reactions to Vaccine Adverse Event Reporting System (VAERS).

You have received and reviewed the Vaccination Information Sheet (VIS) or Emergency Use Authorization Fact Sheet for the COVID-19 vaccine and have been provided time and resources to understand risks and benefits of vaccination. You have also been provided information for V-Safe an active monitoring for any possible side effects. after you receive the vaccine.

The COVID-19 vaccination will reduce the risk of a person contracting SARS-CoV-2, the virus that causes Coronavirus Disease 2019 (COVID-19). Like other vaccines, it takes a few weeks after the vaccine for the body to develop immunity. Some people may still get COVID-19 despite having a vaccination, but this should lessen the severity of infection.

The vaccine **cannot** give a person COVID-19 disease, and two doses will reduce the chance of an individual becoming seriously ill or dying. An eligible person will still need to follow the guidance in place to reduce transmission of COVID-19, such as washing hands frequently, keeping social distance and wearing a face covering when necessary.

Like other vaccines, the COVID-19 vaccine may cause an immunization reaction. Most of these are mild and short-term, and not everyone gets them. Please review the Fact Sheet provided and report reactions by calling 1-800-822-7967 or visiting and www.vaers.hhs.gov. If a reaction is detected, the 2nd dose is recommended unless severe reaction is detected.

YES	NO	Please answer all of the following:
		Are you pregnant today?
		Are you sick or under quarantine period today?
		Do you have any severe allergic reactions to a vaccine component?
		Have you ever had a serious reaction after receiving a vaccination or injectable medication?
		Have you received any vaccinations in the past 2 weeks?
		Do you have a medical condition that causes you to be immunocompromised? Yes – educate regarding effectiveness

☐ I want to receive the full course of COVID-19 vaccination.

☐ Refusal: I understand receiving the COVID-19 vaccination could reduce my risk of COVID-19 infection including severe infection or death, I DO NOT want to receive the COVID-19 vaccination.

Signature: _____ Self Parent Guardian

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Phone: (608) 647-8821 • Fax: (608) 647-6611
E-Mail: rchhs@co.richland.wi.us

Screening complete:

- ☐ Appropriate for vaccination
- ☐ NOT appropriate for vaccination, reason: _____

Clinic Use Only

Manufacturer:	**Route**	**Site Admin.**	**Lot #**	**Expiration date**	**VIS/Fact Sheet Date**
☐ First Dose Date:_____	IM	R L Deltoid			
☐ Second Dose Date:_____	IM	R L Deltoid			

Entered in WIR ☐ Entered in EMR ☐

Ordering Provider: _____

First Dose Administration by: _____ Date: _____

Second Dose Administration by: _____ Date: _____

Staff Use: _____ *Cash* _____ *Check #* _____ *Bill Insurance* _____ *Bill Company*