COVID-19 Vaccine Consent

Cedar County Public Health *400 Cedar St. Tipton, IA *(563) 886-2226

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:

Allergies (Please list):	

PLEASE ANSWER ALL QUESTIONS	CIRCLE ONE	
1. Have you previously received a dose of COVID-19 vaccine? If yes, when?	YES	NO
2. Are you sick today? Been diagnosed with COVID-19 in the past 10 days or exposed to someone who has?	YES	NO
3. Have you received tixagevimab/cilgavimab (EVUSHELD) for COVID-19 pre-exposure prophylaxis?	YES	NO
4. Are you allergic to any foods, medications, vaccines, or latex? (For example: polysorbate, stool softeners, etc.?)	YES	NO
5. Have you ever had severe allergic reaction (anaphylaxis) requiring epinephrine, or for which you went to the hospital?	YES	NO
6. Do you have a bleeding disorder or are you taking a blood thinner?	YES	NO
7. Does your provider consider you immunocompromised, or do you take medication that effects your immune system?	YES	NO
8. **Have you experienced a severe reaction following a previous dose of COVID-19 vaccine—including myocarditis or pericarditis? If yes, please describe:**	YES	NO
9. Within the last 4 weeks have you received the monkeypox vaccine?	YES	NO

CONSENT FOR VACCINATION

- 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 approved or offered under an Emergency Use Authorization by the FDA for the prevention of COVID-19, depending on the age group of persons receiving the vaccine.
- 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 understand my information or the person named above for whom I am authorized to make this request, may be disclosed for research or public health purposes as applicable by law.
- I certify that the information I provided for payment and consent 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 COMPANY NAME:	UNINSURED ◯
IDENTIFICATION NUMBER:	GROUP NUMBER:
NAME OF CARD HOLDER:	BIRTH DATE OF CARD HOLDER: ___ ___ / ___ ___ / ___ ___ ___ ___

This Section for Office Use Only

◯ I have screened this patient for contraindications Nurse's Signature:_____ Date:_____	◯ Left Arm ◯ Left Thigh ◯ Right Arm ◯ Right Thigh	Sticker	In IRIS