COVID-19 Vaccine Consent Primary Series

Moderna/Pfizer/Novavax

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):	***Vaccine Brand Requested:***

PLEASE ANSWER ALL QUESTIONS	CIRCLE ONE	
1. Have you previously received a dose of COVID-19 vaccine? If yes, was it Pfizer, Moderna, Novavax, or Johnson & Johnson?	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. **Dose Number 2 Only, Have there been any changes to your responses to the questions listed above? OR did you experience a severe reaction following a previous dose of COVID-19 vaccine—including myocarditis or pericarditis? If yes, please describe:**	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 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:	
NAME OF CARD HOLDER:	BIRTH DATE OF CARD HOLDER: ___ ___ / ___ ___ / ___ ___ ___ ___

OFFICE USE ONLY	OFFICE USE ONLY	OFFICE USE ONLY
Site:	Site:	Site:
Lot #:	Lot #:	Lot #:
Nurse's Signature:	Nurse's Signature:	Nurse's Signature:
Date:	Date:	Date:
In IRIS ◯ In NN ◯ Billed ◯	In IRIS ◯ In NN ◯ Billed ◯	In IRIS ◯ In NN ◯ Billed ◯