COVID-19 Vaccination Consent Form

Last Name *(Please print)*	First Name	MI	Date of Birth	⌋ Male ⌋ Female ⌋ Other	
Address		City		State	Zip
Phone Number	Email		Name of Primary Care Provider		

SCREENING FOR VACCINATION ELIGIBILITY		
1. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause?	Yes	No
2. Have you had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of a COVID-19 vaccine, including lipid nanoparticles or polyethylene glycol (PEG)?	Yes	No
3. Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?	Yes	No
4. Are you under age 5?	Yes	No
5. Are you currently sick? For example, are you currently experiencing fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.?	Yes	No
6. Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No
7. Have you tested positive for COVID-19 in the last 10 days?	Yes	No
8. Are you currently in quarantine for COVID-19 exposure?	Yes	No
9. Have you been diagnosed with Multisystem Inflammatory Syndrome in adults or children in the last 90 days? (If you answer yes to this question, it is recommended you consult with your physician prior to receiving the COVID-19 vaccine)	Yes	No
10. Have you ever been diagnosed with myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the outer lining of the heart)?	Yes	No
11. If this is your second dose, when was the date of your first dose?	/ /	
12. If this is your second dose, which vaccine did you receive (Pfizer or Moderna)?		
13. Are you moderately to severely immunocompromised?	Yes	No
14. If this is your third dose, when was the date of your second dose?	/ /	
15. If this is your third dose, which vaccine did you receive (Pfizer or Moderna only)?		
16. Do you identify as one of the populations recommended by CDC to receive a booster dose of Pfizer-BioNTech COVID-19 vaccine? For example, are you age 65 or older, 50 to 64 with underlying medical conditions, or 18 or older and live or work in high-risk settings?	Yes	No
17. If this is a booster dose, when was the date of your second dose of Pfizer-BioNTech COVID-19 vaccine?	/ /	

CONSENT FOR VACCINATION

I will/have reviewed my answers to the questions above with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS) provided to me today. I understand the benefits and risks of the vaccine. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

By signing this form, I give permission for a vaccine to be administered to the person above and a record of the vaccination to be entered into the Rhode Island Child and Adult Immunization Registry (RICAIR) for care coordination and to monitor statewide vaccination coverage. For more information about RICAIR, please go to https://health.ri.gov/ricair. Further, I agree that the information above is correct.

Signature of Parent/Guardian/Patient_____Date_____