**Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Brazos County Health District**

**Please circle one: Moderna Pfizer J&J Booster COVID Vaccine Consent Form**

|  |
| --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ Gender: M F Last Name First Name MI Date of Birth Age    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address City State Zip County  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Phone Number Mother’s First Name Mother’s Maiden Name  Race: White Black/African American Asian Native Hawaiian/Pacific Islander American Indian/Alaskan Native  Other Hispanic: Y N |

**Yes No Don’t Know**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Are you feeling sick today? |  |  |  |
| 1. Have you ever had a positive test for COVID-19? |  |  |  |
| 1. Have you ever received a dose of COVID-19 vaccine?   If yes, which vaccine product? Pfizer Moderna Johnson & Johnson |  |  |  |
| 1. Have you received any vaccine in the past 4 weeks? If yes, which one \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 1. Have you ever had a severe allergic reaction (e.g., anaphylaxis)?  * A reaction for which you were treated with Epinephrine or EpiPen, Or you had to go to the hospital? **Yes or No** * If yes, was this reaction after receiving a COVID-19 vaccine? **Yes or No** * Was the severe allergic reaction after receiving another vaccine or another injectable medication? **Yes or No** |  |  |  |
| **6**. Have you ever had a severe allergic reaction to something other than a component of COVID-19 vaccine, polysorbate or any vaccine or injectable medication? Including food, pet, environmental or oral medication allergies. |  |  |  |
| **7**. Do you have a weakened immune system caused by something such as HIV infection or cancer? **Yes or No** Do you take immunosuppressive drugs or therapies? |  |  |  |
| **8.** Do you have a bleeding disorder or are you taking a blood thinner? |  |  |  |
| **9.** Have you received passive antibody therapy as treatment for COVID-19? |  |  |  |
| **10.** Are you pregnant or lactating? |  |  |  |

**For Clinic Use Only:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinical Site: *Brazos County Public Health District***

**Vaccine Lot # Site Given: (R) (L) Deltoid**

**Administered by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I have received the FDA Fact Sheet for Patients and Parents/Caregivers, which includes information on potential risks, benefits, purpose, side effects, dosing methods, and alternative treatment choices for the Vaccine.

I have been informed that the Janssen vaccine has not been approved to prevent COVID-19 by the FDA. The Moderna and Pfizer vaccines have been approved by the FDA to prevent COVID-19. The Moderna and the Janssen vaccines have received Emergency Use Authorization (EUA) from the FDA.

I hereby give my consent to the Brazos County Public Health District (BCHD) to administer the Vaccine I have requested above. I understand the risk and benefits associated with the Vaccine being administered and have received, read and/or had explained to me the written information on the Vaccine I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. I have read and understand the HIPAA form explaining my privacy rights, BCHD’s duty to protect my health information that identifies me and how BCHD may use or disclose health information that identifies me without my written permission. I hereby acknowledge receipt of the BCHD’s “Notice of Privacy Practices” form.

Furthermore, I agree to remain for approximately 15 minutes after vaccine administration for observation.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_