COVID- 19 VACCINE QUESTIONNAIRE/ CONSENT

Last Name													First Name										
Today's Date:							Birth Date:						Cell Number:										

WASHINGTON HEALTH SYSTEM CONSENT FOR ADMINISTRATION OF COVID-19 VACCINE

Risks and Complications: I understand that all vaccines can be associated with risks and complications, including allergic reactions and adverse effects of the drugs. The particular risks and complications associated with this recommended vaccine include, but are not limited to: headache, muscle pains, fatigue, chills, fever and pain at injection site. I understand and acknowledge that this is a new vaccine and other long- term effects may not be known at this time.

Doses: I understand that this vaccine requires two doses to be maximally effective. I agree to receive the second dose of this vaccine approximately 3-4 weeks after my initial dose, as recommended by the FDA. Fully vaccinated individuals can begin receiving their booster shot 8 months after 2nd dose, to maintain protection.

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING YES OR NO:		
Have you been diagnosed with COVID-19 within the past 3 months by PCR or antigen testing or are you currently awaiting the results of a COVID test?	YES	NO
In the past two weeks, have you had contact with anyone who tested positive COVID-19?	YES	NO
Have you had the new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?	YES	NO
Have you had a severe reaction to any previous vaccine?	YES	NO
Do you have severe allergies to any medications, food, insect bites or a previous history of anaphylactic reaction or have you been prescribed an EpiPen for any reason?	YES	NO
Are you actively being treated for any immunocompromising diseases such as cancer, lupus, rheumatoid arthritis or any other autoimmune disease?	YES	NO
For women, are you pregnant, is there a chance you could become pregnant within the next two months after this vaccine dose, or are you breastfeeding?	YES	NO

I certify that I have answered all screening questions accurately and to the best of my ability.

Disclosure of Records: I understand that WHS may be required to or may voluntarily disclose my health information to my Primary Care Physician (if I have one), my insurance plan, health systems and hospitals, and/or state or federal registries for purposes of treatment, payment or other health care operations.

Acknowledgement and Consent: I have received and read the Vaccination Information sheet(s) with regards to the COVID-19 vaccine and I understand the possible side effects and reactions associated with the vaccine. Understanding the benefits and risks of the COVID-19 vaccine, I give my consent to receive the full course of COVID-19 vaccine.

Date: _____ **Signature of Patient:** _____

Date: _____ **Signature of Parent/Guardian:** _____

FOR OFFICE USE ONLY:

COVID – 19 Vaccine

1st dose _____ 2nd dose _____ 3rd dose _____

Dosage: _____ Injection given Intramuscularly in: Right deltoid _____ Left deltoid _____

Lot # _____ Manufacturer: _____ Vaccine expiration date: _____

Signature of Vaccine Administrator: _____

08/2021AB