SIU MEDICINE

Patient COVID-19 Vaccination Consent Form

_____ _____ _____
Patient Name Date of Birth Gender

_____ _____
Home Address City Zip code Phone Number

Race: (Circle one) American Indian/Alaska Native Asian Black or African American Hispanic or Latino
Middle Eastern/North African Native Hawaiian or other Pacific Islander Other race Unknown White

Ethnicity: (Circle one) Hispanic or Latino Not Hispanic or Latino Unknown or prefer not to answer

Indicate Your Answer to the Questions Below:

Mark answer			Question
Yes	**No**		Have you ever received a COVID vaccine? Which vaccine did you receive? Pfizer/Moderna/J&J (circle). Date received: _____ At this SIU site? Y/N
Yes	**No**		Do you have any fever, cough, congestion, sore throat, headache, loss of taste/smell, shortness of breath, nausea, diarrhea or any other upper respiratory symptoms?
Yes	**No**		Have you ever experienced any severe allergic reaction to any vaccine?
Yes	**No**	**N/A**	If you tested positive for COVID-19 in the last 90 days, were you treated with monoclonal antibodies or convalescent plasma?
Yes	**No**	**N/A**	If you have a bleeding or immunocompromised condition, have you consulted with your healthcare provider prior to having the vaccine administered?

- I have been offered a copy of the Emergency Use Authorization for Recipients and Caregivers or Vaccine Information Sheet and I am aware of the vaccine ingredients and side effects and have no known allergies to the listed vaccine ingredients. I understand that the common risks associated with the COVID-19 vaccine include but are not limited to pain, redness or swelling at the site of injection, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, feeling unwell or swollen lymph nodes. I understand that in some people, the vaccine may cause a severe allergic reaction. I understand that these may not be all of the side effects of the COVID-19 vaccine as the vaccine is still being studied in clinical trials. I also understand that it is not possible to predict all possible side effects or complications which could be associated with the vaccine.
- I understand that the Moderna and Pfizer vaccines are a two part vaccine series. I understand that I should receive the second dose as instructed to complete the series. (N/A if receiving the one dose Johnson and Johnson vaccine)
- If I am receiving a 3rd dose because I am immunocompromised, I should receive the same vaccine I received for doses 1 & 2, if possible, either Moderna or Pfizer. If that vaccine is unavailable, I may receive the other mRNA vaccine. Additional doses of Johnson and Johnson vaccine are not recommended at this time. It has been at least 28 days since my last COVID vaccine.
- I agree to wait within the clinic and be observed for at least 15 minutes post vaccine injection.
- I understand and agree that SIU Medicine is required to submit COVID-19 vaccination administration data to ICARE, the Illinois database used for tracking vaccination information.
- I understand and agree that my insurance will be billed for the vaccine administration. I will not be billed for any charges not covered by my insurance or if I am uninsured.
- I have read and understand the information in this consent form. I have had the opportunity to ask questions concerning the vaccine and all of my questions have been answered to my satisfaction. I have made a voluntary informed choice to receive the COVID-19 vaccine and I hereby consent to the staff of SIU Medicine to give me the COVID-19 vaccine. SIU Medicine expressly disclaims any responsibility for the vaccination and related complications.

Signature_____ _____
Patient or Parent/guardian if under 18 years of age Date

Relationship to patient: _____

Circle Series/Dose Number		#1	#2	#3
Circle Injection site:		LEFT ARM		RIGHT ARM
Manufacturer(circle): Pfizer Moderna Johnson & Johnson				
Lot #:	**Expiration date:**	**Vaccinator:**		**Date:**