Today's Date: ______________________

Patient Name: ______________________ DOB ____________

MRN: ______________________

______________________ will receive COVID-19 VACCINE.

Print Name

Demographic Information

Preferred language: ☐ English ☐ Spanish ☐ Other ______________________

Are you homeless? ☐ Yes ☐ No **Are you a Farm Worker?** ☐ Yes ☐ No

Are you a Veteran? ☐ Yes ☐ No

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Caucasian ☐ Native Hawaiian ☐ Pacific Islander
☐ More than one race ☐ Other ☐ Refuse

Within the past 12 months, have you worried that your food would run out before you got money buy more?

☐ Never true ☐ Sometimes true ☐ Often true ☐ Patient Refused

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more?

☐ Never true ☐ Sometimes true ☐ Often true ☐ Patient Refused

Acknowledge Prior to COVID-19 Vaccination

1. Have you had an Immediate or severe allergic reaction of any severity to a previous dose of an mRNA COVID-19 vaccine or any of its components (including polyethylene glycol [PEG])?
2. Do you have a history of severe allergic reaction (such as anaphylaxis or requiring epinephrine injection or hospitalization) to a vaccine, vaccine component, or injectable medication?
3. Have you received monoclonal antibodies or convalescent plasma for treatment of COVID-19?
4. Have you received any other vaccine within the previous 2 weeks?

☐ **No, to all of the above**

☐ **Yes, to one of more of the above.**

Attestation: I have been provided the COVID-19 Vaccine Patient Fact Sheet and offered counsel on each of the above topics. __________

Initial

Consent for COVID-19 Vaccination:

I was given the Patient Fact Sheet(s) for the immunizations listed above. I have read the Patient Fact Sheet(s) or had them explained them to me. I have had the chance to ask questions and I am satisfied with the answers to my questions. I understand the benefits and risks of the vaccines that I will receive today. I understand the vaccines listed may be given singly, in combinations, and/or multiple doses. I give consent that the immunization(s) listed above be administered for all doses.

Signature: ______________________ Parent/Guardian Signature: ______________________

Today's Date: ______________________________
Patient Name: ____________________ DOB __________
MRN: ______________________________________

____ recibirá la VACUNA CONTRA EL COVID-19.
Nombre

Información Demográfica

Preferred language: ☐ Inglés ☐ Español ☐ Otra

¿Está usted sin hogar? ☐ Sí ☐ No **¿Es usted veterano?** ☐ Sí ☐ No

¿Es usted trabajador agrícola? ☐ Sí ☐ No

Etnicidad: ☐ Hispano ☐ No es Hispano

Raza: ☐ Indio Americano ☐ Asiáticon ☐ Negro/afroamericano
☐ Caucásico ☐ Nativo hawaiano ☐ Islas del Pacífico
☐ Más de una raza ☐ Otra ☐ El paciente se negó

Within the past 12 months, have you worried that your food would run out before you got money buy more?
☐ Never true ☐ Sometimes true ☐ Often true ☐ Patient Refused

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more?
☐ Never true ☐ Sometimes true ☐ Often true ☐ Patient Refused

Verificación antes de recibir la vacuna contra el COVID-19

1. ¿Tiene antecedentes de alguna reacción alérgica severa (tal como anafilaxis, o ha requerido una inyección de epinefrina u hospitalización) debido a alguna vacuna, componente de vacuna o medicamento inyectable?
2. ¿Ha recibido anticuerpos monoclonales o plasma convaleciente para el tratamiento del COVID-19?
3. ¿Tiene antecedentes de desmayos después recibir una inyección?

☐ **No, a todas las preguntas anteriores.**

☐ **Sí, a una o más de las preguntas anteriores.**

Declaración: Se me ha proporcionado la hoja informativa para el paciente sobre la vacuna contra el COVID-19 y ofrecido consejo sobre cada uno de los temas anteriores. __________
Iniciales

Consentimiento para recibir la vacuna contra el COVID-19:

Se me entregaron las hojas informativas para el paciente sobre las vacunas mencionadas anteriormente. He leído las hojas informativas para el paciente o se me han explicado. He tenido la oportunidad de hacer preguntas y estoy satisfecho con las respuestas a mis preguntas. Entiendo los beneficios y riesgos de las vacunas que recibiré hoy. Entiendo que las vacunas enumeradas pueden administrarse por separado, en combinación y/o en dosis múltiples. Doy mi consentimiento para que se administren todas las dosis de la(s) vacuna(s) enumerada(s) anteriormente.

Firma: ______________________________ Firma del padre/tutor: ______________________