

**HAMPSHIRE COUNTY HEALTH DEPARTMENT
COVID-19 IMMUNIZATION CONSENT FORM**

Last Name: _____ First Name: _____ MI: _____

Parent/Guardian Name: _____

Mailing Address: _____

Physical Address: _____

City: _____ County: Hampshire State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: Male Female

Race (select all that apply): American Indian/Alaskan Native Asian Black/African American
 Native Hawaiian or Pacific Islander White Other Race

Ethnicity (select all that apply): Hispanic or Latino Not Hispanic or Latino Unknown

If you will be receiving the COVID-19 vaccine, please answer these questions:	YES	NO
Are you feeling sick today?		
Have you ever received a dose of the COVID-19 vaccine? If yes, what brand: _____		
Have you had a severe allergic reaction to any vaccine or injectable therapy?		
Are you receiving immunosuppressive medications or have an immunocompromising condition?		
Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		
Have you received monoclonal antibody treatment or convalescent plasma for COVID treatment within the last 90 days?		
Do you have a weakened immune system caused by something such as HIV infection or cancer?		
Do you take immunosuppressive drugs or therapies?		
Do you have a bleeding disorder or are you taking a blood thinner?		
Have you received any other vaccines within the past 14 days?		
Are you pregnant or breastfeeding?		

I have received, read, and/or have had explained to me the information about the vaccine (i.e., Emergency Use Authorization (EUA) factsheet). I have had a chance to ask questions that were answered to my satisfaction. I believe that I understand the vaccine's benefits and risks and request that the vaccine is given to me. I understand that this is a two-dose vaccine series, and I will be required to return for a 2nd dose.

Parent/Guardian Signature: _____ Date: _____

STAFF USE ONLY

Dose 1 or Dose 2 (circle one)

Site: R L Deltoid

Route: IM

Vaccine (circle one) **Pfizer** Moderna Lot#: _____

Vaccine Administered by: _____ Date: _____