COBB & DOUGLAS PUBLIC HEALTH
Healthier lives. Healthier community.

Patient # _____

COVID-19 VACCINE CONSENT FORM

PLEASE PRINT INFORMATION FOR PERSON RECEIVING VACCINE

Last Name, First Name, Middle Initial	Date of Birth (mm/dd/yyyy)	Age	Phone Number ( )

Street Address	City	County	State	Zip

Email Address

Race – You May Check More Than One Category
☐ African American ☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Ethnicity
◯ Hispanic
◯ Non-Hispanic

Gender
◯ Male
◯ Female

Allergies

Are you, or could you be, pregnant? ◯ Yes ◯ No

Do you have an immunocompromising condition? ◯ Yes ◯ No

Have you ever received a COVID-19 vaccine before? ◯ Yes ◯ No
IF YES, date vaccine received: _____ and vaccine manufacturer: _____

SIGNED CONSENT

Are you sick today, or have you had a fever in the past two days?	◯ Yes	◯ No
Have you EVER had a life-threatening allergic reaction after a dose of any vaccine or injectable medication?	◯ Yes	◯ No
Have you had any vaccine within the past 14 days, or do you plan to receive another vaccine within the next 14 days?	◯ Yes	◯ No
Are you currently under isolation (infected with COVID-19) or under quarantine (exposed to someone with COVID-19)?	◯ Yes	◯ No
Do you have a bleeding disorder or are you currently taking a blood thinner?	◯ Yes	◯ No
Have you received monocolonal antibody therapy or convalescent plasma for COVID-19 treatment in the past 90 days?	◯ Yes	◯ No
Have you EVER had a severe (life-threatening) allergy to any component of this vaccine as detailed in the Emergency Use Authorization Fact Sheet?	◯ Yes	◯ No

I (person receiving vaccine) have:

- received, read, and understand the Emergency Use Authorization Fact Sheet and/or Vaccine Information Statement for the vaccine I am receiving;
- received the Cobb & Douglas Public Health HIPAA Notice of Provider Privacy Practices;
- had the opportunity to discuss any medical concerns with my healthcare provider or a healthcare provider at the time of my vaccination.

PLEASE ASK QUESTIONS BEFORE RECEIVING THE COVID-19 VACCINE.
I understand the risks of this vaccine and ask that this vaccine be given to me or to the person named above for whom I am authorized to make this request

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Patient (If Applicable)

FOR COBB & DOUGLAS PUBLIC HEALTH USE ONLY

Vaccine Type	Center	Date Vaccinated	Dose/Route/Site	Mfg./Lot#/Exp. Date

_____ _____
Provider Printed Name Provider Signature / Title