Shasta Regional Medical Center

CA264B1001

mRNA COVID-19 Vaccine Consent Form & Administration Record

NAME: (Last) (First) (M.I.)	☐ Male ☐ Female DOB:	Department:

Address:	Phone Number:	Email Address:

Race: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Native American ☐ Polynesian ☐ Other ☐ Decline

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other ☐ Decline

Contraindications and Precautions

☐ YES ☐ NO 1. Are you sick today?

☐ YES ☐ NO 2. Do you have a fever or other symptoms associated with COVID-19 such as cough, chills, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea today?

☐ YES ☐ NO 3. Have you had close contact (been within 6 feet for a total of 15 minutes in a 24-hour period) with anyone who tested positive for COVID-19 or provided care to a COVID-19 patient without wearing a face mask/N95 and eye protection the past 14 days?

☐ YES ☐ NO 4. Have you recently been diagnosed with COVID-19?
If yes, answer the following:

- ☐ YES ☐ NO a. Has it been at least 10 days?
- ☐ YES ☐ NO b. Have you been fever-free for at least 24 hours without the use of fever-reducing medication?
- ☐ YES ☐ NO c. Have you had improvement in symptoms for at least 24 hours?

☐ YES ☐ NO 5. Have you received any other vaccines with the past 14 days?

☐ YES ☐ NO 6. Have you ever had a severe allergic reaction to an mRNA COVID-19 vaccine (Pfizer-BioNTech or Moderna) or any component an mRNA-COVID-19 vaccine?

☐ YES ☐ NO 7. Have you ever had a severe allergic reaction (anaphylaxis) to any vaccine or injectable therapy (intramuscular, intravenous or subcutaneous) or any history of other substance?

☐ YES ☐ NO 8. Do you have any history of severe allergic reaction (anaphylaxis)?

☐ YES ☐ NO 9. Do you have a condition or are you taking any medication that suppresses your immune system, such as for cancer, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease or any other immune system problem?

☐ YES ☐ NO 10. Do you have a weakened immune system or in the past 3 months taken medications that weaken it such as cortisone, prednisone, other steroids, anticancer drugs or radiation treatment?

☐ YES ☐ NO 11. Have you received a previous dose of the COVID-19 vaccine?
If yes, answer the following:

- ☐ Pfizer ☐ Moderna a. Which vaccine did you receive?
- ☐ YES ☐ NO ☐ N/A b. If yes to the Pfizer vaccine, has it been 17-21 days since the first dose?
- ☐ YES ☐ NO ☐ N/A c. If yes to the Moderna vaccine, has it been 24-28 days since the first dose?

☐ YES ☐ NO 12. Have you received monoclonal antibodies or convalescent plasma for treatment of COVID-19 within the last 90 days?

☐ YES ☐ NO 13. Are you currently pregnant?

☐ YES ☐ NO 14. Are you breastfeeding?

☐ YES ☐ NO 15. Do you take anticoagulation medications such as warfarin, Coumadin, or other blood thinners?

☐ YES ☐ NO 16. Are you under age 18?

REVIEWER NAME AND SIGNATURE:	DATE:	TIME:

Shasta Regional Medical Center

CA264B1001

NAME: (Last)	(First)	(M.I.)	DOB:

CONSENT FOR VACCINATION

- I, the undersigned, have been provided a copy of the Vaccine Fact Sheet that discusses the risks and benefits of the COVID-19 vaccine. I understand the benefits and risks, have been given opportunity to ask questions with answers to my satisfaction and consent to administration of the vaccine.
- I understand that the COVID-19 vaccine requires two (2) doses to confer immunity and if I do not complete the full series then I will not receive the full benefit of the vaccine. I understand that a second dose is subject to vaccine supply from the manufacturer. As with any vaccine, there is no certainty that I will become immune or that I will not experience any adverse side effects from the vaccine. I voluntarily assume full responsibility for any events that may result due to vaccination.
- I understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand that I should report any adverse effects to both my provider and vaccine administrator.
- I understand that my employer or vaccine administrator is not responsible for my medical care and therefore I must discuss any medical concerns or care needs with my healthcare provider. I understand that if I experience any serious adverse reactions, I should call 911 or go to the nearest hospital. If I experience any adverse effects or have medical concerns, I should contact my healthcare provider. Even after immunization is complete, I will continue to follow all COVID-19 safety guidelines as required by my employer or recommended by the CDC and state/local health authorities.

☐ **I ATTEST that I have answered all screening questions to the best of my knowledge.**

☐ **I GIVE CONSENT to this hospital and its staff to vaccinate me with the COVID-19 Vaccine.**

SIGNATURE:	DATE:	TIME:

VACCINE DECLINATION STATEMENT

- I understand that due to occupational exposure to potentially infectious persons and/or materials, I may be at risk of acquiring COVID-19. I have been given the opportunity to be vaccinated with the COVID-19 vaccine at no cost. However, I decline the COVID-19 vaccination.
- I understand that by declining this vaccine, I continue to be at risk of contracting COVID-19. Because there is widespread community transmission of COVID-19, I also understand that by declining this vaccine, I am at risk of potentially spreading COVID-19 to others.
- I Acknowledge that if my personal choices involving the vaccine change, I can request to receive the COVID-19 vaccine in the future at no charge (subject to availability). All my questions regarding the risk of acquiring COVID-19 and the COVID-19 vaccination process have been answered to my satisfaction.

☐ **I have already received the COVID-19 vaccination,** and I will provide that documentation for my employee health file.

☐ **I DO NOT GIVE CONSENT to this hospital to vaccinate me with the COVID-19 Vaccine.**

SIGNATURE:	DATE:	TIME:

VACCINATION RECORD

FOR ADMINISTRATIVE USE ONLY

Vaccine Manufacturer	Site	Lot Number	Expiration Date	Dose
☐ Pfizer-BioNTech 30 mcg/0.3 mL IM ☐ Moderna mRNA-1273 100 mcg/0.5 mL IM	☐ Left Deltoid ☐ Right Deltoid			☐ First Dose ☐ Second Dose

PRINT NAME & SIGNATURE OF VACCINE ADMINISTRATOR:	DATE:	TIME: