MMHC COVID-19 VACCINE INFORMATION AND CONSENT

Name: _____ _____ _____
First Middle Last

Address: _____ _____ _____
Street City State Zip

Telephone: (___)_____--_____

Date of Birth: _____--_____--_____	**Age**	**Gender:** ☐ Male ☐ Female	**Primary Language:** ☐ English ☐ Other _____	**Ethnicity: (check only 1)** ☐ Not Hispanic ☐ Hispanic ☐ Unknown

Race: (check only 1) Asian/Polynesian Black White Multiracial Native Am/Alaskan Unknown

Emergency Contact
Phone#: _____
Name:

Please answer the health questions below:	**Yes**	**No**	**Unknown**
1. Are you sick today or currently in an isolation or quarantine period for COVID-19?			
2. Have you had a positive COVID-19 test in the last 3 months/90 days?			
3. Have you received passive antibody therapy as treatment for COVID-19?			
4. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something requiring emergency medication or hospital visit?			
5. Have you ever had a serious reaction after receiving a vaccine or another injectable medication?			
6. Have you received any vaccinations in the past two weeks/14 days?			
7. Do you have a bleeding disorder or are you taking a blood thinner?			
8. Do you currently have a weakened immune system, take immunosuppressive medications, or receive radiation or chemotherapy treatment?			
9. Are you pregnant or currently breastfeeding?			
10. Do you have dermal fillers			
11. Have you ever received a dose of COVID-19 vaccine? If yes, which (circle one)? Pfizer Moderna Janssen Date received: ____			

- I have been given a copy of the COVID-19 vaccine **FACT SHEET**. I understand the FDA has authorized emergency use of COVID-19 vaccine, which is not an FDA-approved vaccine. I have had the chance to ask questions that were answered to my satisfaction. I understand the significant known and potential risks and benefits of COVID-19 vaccine as explained in the **FACT SHEET** and that some potential risks and benefits may remain unknown. **I REQUEST THE COVID-19 VACCINE BE GIVEN TO ME OR THE PERSON LISTED ABOVE.**
- **I understand COVID-19 vaccine requires 2 doses given 4 weeks apart. I intend to receive a second dose as scheduled today.**
- **My signature acknowledges that I was advised to remain on site for 15 minutes or 30 minutes after receiving the vaccine depending upon my history of previous reactions.** I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician.

_____ **X** _____
Date **Print Name** **Patient or Parent/Guardian Signature**