SIU MEDICINE
FORWARD. FOR YOU.

Patient COVID-19 Vaccination Consent Form

_____ _____ _____
Patient Name Date of Birth Gender

_____ _____ _____
Home Address City Zip code Phone Number

Indicate Your Answer to the Questions Below:

Mark answer			**Question**
Yes	**No**		Have you ever received a COVID vaccine? Which vaccine did you receive? Pfizer/Moderna (circle). Date received: _____ At this SIU site? Y/N
Yes	**No**		Do you have any fever, cough, congestion, sore throat, headache, loss of taste/smell, shortness of breath, nausea, diarrhea or any other upper respiratory symptoms?
Yes	**No**		Have you had any vaccines in the previous 14 days?
Yes	**No**		Have you ever experienced any severe allergic reaction to any vaccine?
Yes	**No**		Have you tested positive for COVID-19 in the last 28 days?
Yes	**No**	**N/A**	If you tested positive for COVID-19 in the last 90 days, were you treated with monoclonal antibodies or convalescent plasma?
Yes	**No**	**N/A**	If you are pregnant or a nursing mom, have a bleeding or immunocompromised condition, have you consulted with your healthcare provider prior to having the vaccine administered?

- I have been offered a copy of the Emergency Use Authorization for Recipients and Caregivers or Vaccine Information Sheet and I am aware of the vaccine ingredients and side effects and have no known allergies to the listed vaccine ingredients. I understand that the common risks associated with the COVID-19 vaccine include but are not limited to pain, redness or swelling at the site of injection, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, feeling unwell or swollen lymph nodes. I understand that in some people, the vaccine may cause a severe allergic reaction. I understand that these may not be all of the side effects of the COVID-19 vaccine as the vaccine is still being studied in clinical trials. I also understand that it is not possible to predict all possible side effects or complications which could be associated with the vaccine.
- I understand that the Moderna and Pfizer vaccines are a two part vaccine series. By signing this consent, I am agreeing that I will receive both parts of the vaccine series by the same manufacturer, administered by SIU. (N/A if receiving the one dose Johnson and Johnson vaccine)
- I agree to wait within the clinic and be observed for at least 15 minutes post vaccine injection.
- I understand and agree that SIU Medicine is required to submit COVID-19 vaccination administration data to ICARE, the Illinois database used for tracking vaccination information.
- I understand and agree that my insurance will be billed for the vaccine administration. I further agree that if I do not have insurance or my insurance does not cover the cost of the COVID-19 vaccine, SIU Medicine may bill me a required fee. SIU Medicine cannot guarantee that this service will be reimbursable by insurance.
- I have read and understand the information in this consent form. I have had the opportunity to ask questions concerning the vaccine and all of my questions have been answered to my satisfaction. I have made a voluntary informed choice to receive the COVID-19 vaccine and I hereby consent to the staff of SIU Medicine to give me the COVID-19 vaccine. SIU Medicine expressly disclaims any responsibility for the vaccination and related complications.

_____ _____
Signature Date

	Circle Series/Dose Number	#1	#2
	Circle Injection site:	LEFT ARM	RIGHT ARM
Manufacturer:			
Lot #:	**Expiration date:**	**Vaccinator:**	