PHYSICIANS' CLINIC
of Iowa, P.C.

COVID-19 VACCINE CONSENT FORM

Name _____ Date of Birth: _____ Today's Date _____

The following questions will help determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask someone to explain it.

Are you feeling sick today? ☐ Yes ☐ No ☐ Unsure Have you ever received a dose of COVID-19 vaccine? ☐ Yes ☐ No

- If the answer is yes, which vaccine product? ☐ Pfizer ☐ Moderna ☐ Another product: _____

Have you ever had a severe allergic reaction (eg. anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital? ☐ Yes ☐ No ☐ Unsure

- Was the severe allergic reaction after receiving a COVID-19 vaccine? ☐ Yes ☐ No ☐ Unsure
- Was the severe allergic reaction after receiving another vaccine or another injectable medication? ☐ Yes ☐ No ☐ Unsure

Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19? ☐ Yes ☐ No ☐ Unsure

Have you received another vaccine in the last 14 days? ☐ Yes ☐ No ☐ Unsure

Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? ☐ Yes ☐ No ☐ Unsure

Do you have a weakened immune system caused by something such as HIV infection or cancer, or do you take immunosuppressive drugs or therapies? ☐ Yes ☐ No ☐ Unsure

Do you have a bleeding disorder or are you taking a blood thinner? ☐ Yes ☐ No ☐ Unsure

Are you pregnant or breastfeeding? ☐ Yes ☐ No ☐ Unsure

I have read the information regarding the COVID-19 virus and vaccine. I had an opportunity to ask questions and understand the benefits and risks of the COVID-19 vaccination. As with all medical treatment, I understand that there is no guarantee that I will become immune or that I will not experience and an adverse side effect from the vaccine. By signing below, I release PCI and persons administering the vaccine from any liability in the administration of this vaccine and hereby give my informed consent.

☐ **I request that the vaccine be given to me.** ☐ **I have received information regarding the CDC's v-safe program.**

Signature: _____

Family Physician: _____

Date Given: _____ Site: ☐ Left Deltoid ☐ Right Deltoid

Manufacturer: _____

Lot Number: _____

Expiration Date: _____

Vaccine Administered By:

Signature: _____

Printed Name: _____