



CAMERON COUNTY PUBLIC HEALTH

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COVID-19 VACCINATION CONSENT FORM

| | | | | | | |
|---|--|--|---------------------|--|---------------|--|
| First Name (Print) | | Last Name | | M.I. | Date of Birth | Age |
| Address | | | | City | | State ZIP |
| Phone Number | | <input type="checkbox"/> Male <input type="checkbox"/> Female | Mother's First Name | | | |
| Race | | Ethnicity | | <input type="checkbox"/> I do not wish to disclose | | |
| <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | | <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American | | <input type="checkbox"/> White <input type="checkbox"/> Other | | <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino |

I am 50 years or older.

SCREENING FOR VACCINATION ELIGIBILITY

You should **not** get vaccinated if you:

- are under 18 years of age.
- had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause.
- had a severe allergic reaction (e.g., anaphylaxis, trouble breathing) to any component of a COVID-19 Vaccine, including lipid nanoparticles or polyethylene glycol (PEG).
- received any other vaccine within the past 14 days or are scheduled to receive any vaccine in the next 14 days.
- received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days.

Talk to your doctor about whether you should receive the COVID-19 vaccine if you:

- are pregnant or breastfeeding.
- are currently sick. For example, if you are experiencing fever, chills cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, etc.
- have a bleeding disorder or are taking a blood thinner.
- are currently in quarantine for COVID-19.
- have tested positive for COVID-19 in the past 90 days.

Do you have any of the following conditions? (Check all that apply.)

- | | | | | |
|---|--|--|---|---------------------------------------|
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Obesity/Severe Obesity | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Smoker | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Stroke | <input type="checkbox"/> None of the above | <input type="checkbox"/> Other: _____ | |

Do you have any of the following immunocompromised conditions? (Check all that apply.)

- | | | | | |
|---|--|--|-----------------------------------|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Transplant |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Other: _____ | | | | |

CONSENT FOR VACCINATION

I've had the opportunity to discuss my concerns with my doctor. If I experience any adverse effects after leaving, I will notify my primary care provider and administrator. **I have reviewed the Emergency Use Authorization face sheet provided to me today.** The administration of this vaccine does not create a patient provider relationship between administrator and recipient. I understand that my information and vaccination status will be reported to the state. I understand the benefits and risks of the vaccine and freely and voluntarily request to receive the COVID-19 vaccine.

Signature of Parent/Guardian/Patient: _____ Date: _____

FOR ADMINISTRATIVE USE ONLY:

| | | | |
|---------------|------------|---|-------------------------------------|
| Manufacturer: | Exp. Date: | Route IM: | Time/Date Vaccine Given: |
| Lot #: | | <input type="checkbox"/> Right Deltoid <input type="checkbox"/> Left Deltoid | Signature of Vaccine Administrator: |