HCA COVID-19 Vaccination Consent Form

Basic Information

Please provide your personal information and answers to the vaccination questions below.
Fields marked with an asterisk(*) are required

Legal First Name* _____ Date of Birth* _____

Middle Name _____ Gender* _____

Legal Last Name* _____ Race* _____

Ethnicity* ☐Hispanic / ☐Non-Hispanic

Contact Information

Please supply the best information to reach you for questions.

Phone Number* _____ Street Address* _____

Mobile Phone Number* _____ Street Address 2 _____

Email Address* _____ City* _____

State* _____

Zip* _____

Emergency Contact Information

Name _____ Phone Number _____

COVID-19 Vaccination: ☐ Consent: I am at least 18 years of age and consent to receive the COVID-19 Vaccination

Please read the following questions carefully and indicate your answers in the field provided.
Medical Conditions (these are voluntary and will not prevent you from receiving the vaccine)

▪ Asthma	☐ Yes	☐ No	☐ Prefer Not to Answer
▪ Cancer	☐ Yes	☐ No	☐ Prefer Not to Answer
▪ Cerebrovascular Disease	☐ Yes	☐ No	☐ Prefer Not to Answer
▪ Chronic Kidney Disease	☐ Yes	☐ No	☐ Prefer Not to Answer
▪ COPD (Chronic Obstructive Pulmonary Disease)	☐ Yes	☐ No	☐ Prefer Not to Answer
▪ Have you been sick in the last 30 days?	☐ Yes	☐ No	☐ Prefer Not to Answer
▪ High Blood Pressure	☐ Yes	☐ No	☐ Prefer Not to Answer
▪ Immunocompromised state from solid organ transplant	☐ Yes	☐ No	☐ Prefer Not to Answer
▪ Obesity (BMI 30 or higher)	☐ Yes	☐ No	☐ Prefer Not to Answer
▪ Serious Heart Conditions	☐ Yes	☐ No	☐ Prefer Not to Answer
▪ Sickle Cell Disease	☐ Yes	☐ No	☐ Prefer Not to Answer
▪ Smoking	☐ Yes	☐ No	☐ Prefer Not to Answer
▪ Type 2 Diabetes	☐ Yes	☐ No	☐ Prefer Not to Answer

Disclosures of genetic information is not being asked in this consent.
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except specifically allowed by this law. To comply with this law we are asking that you not provide any genetic information when responding to any request that may seek medical information. "Genetic Information." As defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or a family member receiving assistive reproductive services.

Contraindications:

If you have any of the conditions below, it is recommended that you do not receive the COVID-19 vaccination without speaking to your healthcare provider.

Pfizer-BioNTech COVID-19 Vaccine

The Manufacturer advices against administration of the Pfizer-BioNTech COVID-19 Vaccine to individuals with known history of severe allergic reaction (e.g, anaphylaxis) to any compound of the Pfizer-BioNTech COVID-19 Vaccine. The Pfizer-BioNTech COVID-19 Vaccine includes the following ingredients: mRNA, lipids ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-Distearoyl-sn-glycero-3- phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose.

Moderna COVID-19 Vaccine

The Manufacturer advices against administration of Moderna COVID-19 Vaccine to individuals with known history of severe allergic reaction (e.g, anaphylaxis) to any compound of the Moderna COVID-19 Vaccine. The Moderna COVID-19 Vaccine contains the following ingredients: messenger ribonucleic acid (mRNA), lipids (SM-102, polyethylene glycol [PEG] 2000 dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose.

- Do you have a history of an allergic reaction to any of these ingredients listed above? ☐ Yes ☐ No ☐ Prefer Not to Answer
- Do you have a history of severe allergic reactions such as immediate- onset anaphylaxis to a vaccine? ☐ Yes ☐ No ☐ Prefer Not to Answer
- Do you have a history of severe allergic reactions, such as immediate-onset anaphylaxis to medicine or food? ☐ Yes ☐ No ☐ Prefer Not to Answer
- Are you pregnant? ☐ Yes ☐ No ☐ Prefer Not to Answer
  - The vaccine trials to date have not included pregnant women; based on how mRNA vaccines work, experts believe they are unlikely to pose a risk for people who are pregnant. ☐ I Acknowledge
- Have you received any vaccine (pneumococcal, flu) within the last 14 days? ☐ Yes ☐ No ☐ Prefer Not to Answer

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For Nurses Only

Dose 1

3-4 ID of Vaccinator: _____
3-4 ID of Triage: _____

Contraindications

Have any of these contraindications changed since the participant consented? ☐ Yes ☐ No

IF YES, please identify what contraindications changed

Do you have a history of an allergic reaction to any of these ingredients listed above? ☐ Yes ☐ No ☐ Prefer Not to Answer

Do you have a history of severe allergic reactions such as an immediate-onset anaphylaxis to a vaccine?
☐ Yes ☐ No ☐ Prefer Not to Answer

Do you have a history of severe allergic reactions, such as immediate-onset anaphylaxis to medicine or food?
☐ Yes ☐ No ☐ Prefer Not to Answer

Do you have a history of severe allergic reactions, such as immediate-onset anaphylaxis to medicine or food?
☐ Yes ☐ No ☐ Prefer Not to Answer

Are you pregnant?
☐ Yes ☐ No ☐ Prefer Not to Answer

The vaccine trials to date have not included pregnant women; based on how mRNA vaccines work, experts believe they are unlikely to pose a risk for people who are pregnant. ☐ I Acknowledge

Does the participant qualify for the COVID-19 Vaccination?
☐ Yes ☐ No

Dose 2

3-4 ID of Vaccinator: _____
3-4 ID of Triage: _____

Contraindications

Have any of these contraindications changed since the participant consented? ☐ Yes ☐ No

IF YES, please identify what contraindications changed

Do you have a history of an allergic reaction to any of these ingredients listed above? ☐ Yes ☐ No ☐ Prefer Not to Answer

Do you have a history of severe allergic reactions such as an immediate-onset anaphylaxis to a vaccine?
☐ Yes ☐ No ☐ Prefer Not to Answer

Do you have a history of severe allergic reactions, such as immediate-onset anaphylaxis to medicine or food?
☐ Yes ☐ No ☐ Prefer Not to Answer

Do you have a history of severe allergic reactions, such as immediate-onset anaphylaxis to medicine or food?
☐ Yes ☐ No ☐ Prefer Not to Answer

Are you pregnant?
☐ Yes ☐ No ☐ Prefer Not to Answer

The vaccine trials to date have not included pregnant women; based on how mRNA vaccines work, experts believe they are unlikely to pose a risk for people who are pregnant. ☐ I Acknowledge

Outside of dose one of this series, have you received anther Covid-19 Vaccine? ☐ Yes ☐ No
Did you experience a severe allergic reaction after previous dose of COVID-19 vaccine? ☐ Yes ☐ No
Does the participant qualify for the COVID-19 Vaccination? ☐ Yes ☐ No

Vaccination Details:

Date: _____

Shot Location (on the body): _____

MVX (manufacturer): _____

Lot Number: _____

CVX (product): _____

Expiration Date: _____

Administered at Location

Facility Name: _____

Facility ID: _____

Street: _____

City: _____

State: _____

Zip: _____

Vaccination Details:

Date: _____

Shot Location (on the body): _____

MVX (manufacturer): _____

Lot Number: _____

CVX (product): _____

Expiration Date: _____

Administered at Location

Facility Name: _____

Facility ID: _____

Street: _____

City: _____

State: _____

Zip: _____

Signature

I understand that the information completed on this form is correct to the best of my knowledge and that if a vaccine is administered, it may be required to share this information with state and/or federal jurisdictions. By checking this box I hereby agree that the check mark serves as my electronic signature on this form.

Initials: _____

Signature: _____ Date: _____

(MM/DD/YYYY)