Broward Health

Consent Form for Administration of COVID-19 Vaccination

Patient Name: _____

Date of Birth: _____ Age: _____ Gender (circle one): Male / Female

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ (home); _____ (work); _____(mobile)

Emergency Contact: _____; telephone: _____

Primary physician: _____; telephone: _____

Screening Questions (if you answer yes, please explain below)	Please circle	
1. Are you sick today or have you had an illness in the last 30 days or a COVID diagnosis in the last 90 days or have you received convalescent plasma?	Yes	No
2. Do you have allergies to medications, food, a vaccine component, or latex?	Yes	No
3. Have you ever had a serious reaction after receiving a vaccination?	Yes	No
4. Do you have a long-term health problem with anemia, low platelets or other blood disorder, or have you had a problem with an IM injection.	Yes	No
5. Do you have cancer, leukemia, AIDS, or any other immune system disorder?	Yes	No
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	Yes	No
7. Have you had Guillain Barre Syndrome?	Yes	No
8. For women: Are you pregnant/breastfeeding or is there a chance you could become pregnant during the next 3 months?	Yes	No
9. Have you received any vaccinations in the past 4 weeks?	Yes	No

If you answered "Yes" to any of the foregoing questions, please explain:

_____
_____
_____
_____
_____

I hereby acknowledge the following:

Broward Health

Consent Form for Administration of COVID-19 Vaccination

_____ I understand that I am not required to receive the Vaccine; however, I have voluntarily chosen to receive the Vaccine and accept all known and potential risks related to receiving the Vaccine.

_____ I have been provided with a copy of, and reviewed the contents of, the attached Vaccine Information Sheet (VIS) or Emergency Use Authorization (EUA)

_____ The undersigned Provider Representative has explained to me, and I understand that:

_____ Known potential adverse reactions to the Vaccine include each of the potential adverse reactions identified in the VIS or EUA provided to me.

_____ There may be additional adverse reactions to the Vaccine that are not identified in the VIS or EUA provided to me.

_____ I have had the opportunity to ask questions concerning the Vaccine, the administration of the Vaccine and potential adverse health consequences of receiving the Vaccine, and all of my questions have been answered to my satisfaction.

_____ I understand that my failure to provide full and accurate information regarding my health status may result in adverse health consequences to me, including without limitation _____.

_____ I have provided full and truthful information for the completion of this Consent Form.

Consent and waiver: I consent to the administration of the Vaccine by representatives of Broward Health. I fully release and discharge Broward Health, its affiliates and their officers, directors, employees and persons acting on their behalf or at their direction from any liability or claim related to the administration of, or my receipt of, the Vaccine.

Signature of patient or Legal Guardian:_____Date:_____

To be completed by Hospital/System representative

☐ Medication:_____ VIS/EUA Date: _____ Lot #:_____ Exp Date: _____ Site: ____

☐ Medication:_____ VIS/EUA Date: _____ Lot #:_____ Exp Date: _____ Site: ____

Administered by: _____ Title: _____ Date Given:_____