Informed Consent for COVID-19 Vaccine

_____ Initials

I verify that I have been provided with and have read the Emergency Use Authorization Fact Sheet for the appropriate COVID-19 vaccine. I acknowledge that I have had a chance to ask questions of a medical professional about the COVID-19 vaccine. I understand the known risks and the potential benefits of receiving the COVID-19 vaccine, as described in the Fact Sheet. I request and consent to the COVID-19 vaccine being given to me.

_____ Initials

I understand it is recommended that I remain on site for at least 15 minutes after receiving the COVID-19 vaccine and that, depending on the recommendation of medical professionals, I may be asked to remain on site longer for monitoring.

_____ _____

Signature of the vaccine recipient Date

_____ _____

Print name legibly Date of Birth

☐ 1st DOSE

☐ 2nd DOSE

COVID vaccine manufacturer:_____ Lot #_____ Expiration _____

Injection site: ____Left deltoid ____Right deltoid Other: _____(please specify)

Administered by:_____ Date/Time given: _____