Heart of America
medical center

COVID-19 Vaccine Consent Form

Section 1: Information about person to receive vaccine (*please print*)

Name (Last)	(First)	(M.I.)
Date of Birth Month _______ Day _______ Year _______		

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if you can get the COVID-19 vaccine. If you answer "NO" to all four of the following questions, you can get the COVID-19 vaccine. If you answer "YES" to one or more of the following questions, you may not be able to get the COVID-19 vaccine.

Please mark **YES** or **NO** for each question.

	YES	NO
1. Do you have allergies to latex, medications, food or vaccines (e.g. eggs, bovine protein, gelatin, gentamicin, polymixin, neomycin, phenol, yeast or thimerosal)?		
2. Have you ever had an anaphylactic or severe reaction to a medication or vaccine in the past?		
3. Have you ever had Guillain-Barre` Syndrome, a seizure disorder, brain disorder or other nervous system problem?		
4. **For Women:** Are you pregnant, planning to become pregnant, or breastfeeding? If yes, we advise you to consult your primary health care provider prior to receiving the vaccine.		
5. Have you had any vaccines in the last 14 days?		
6. Have you tested positive for COVID-19? If so, date _____________ Did you receive any monoclonal antibody treatment for COVID? (eg. Bamlinivimab or Regeneron) If so, date _____________		
7. Are you over the age of 18?		

Section 3: Consent

CONSENT FOR VACCINATION

I have read or had explained to me the Emergency Use Authorization Fact Sheet for the COVID-19 vaccine and understand the risks and benefits.

☐ **I GIVE CONSENT** to the Heart of America Medical Center to be vaccinated with this vaccine.

☐ **I DO NOT GIVE CONSENT** to the Heart of America Medical Center to be vaccinated with this vaccine.

Signature: ____ **Date:**___________________