Comprehensive Internal Medicine--A Tradition of Excellence in Medical Care

Anju Bhushan, MD Jacqueline T Pearson, MD, MS Arezou Fatemi, MD Ryan Bozof, MD

Laurae Carpenetti, MD Carol Hector, MD Sudeshna Nandi, MD

Board Certified, Diplomates of the American Board of Internal Medicine

Sumera Pervaiz, MD

Board Certified Family Medicine

Shima Mansouri, PA-C Petula Gunn, ARPN

COVID-19 VACCINE CONSENT FORM

Name: ___________________________________ **Birth date**: ___/___/_____ **Age**: _______ **Sex**: ☐ Male ☐ Female

Address: _________________________________ **City**: ____________________________ **State**: ______ **Zip**: _______

Phone: __________________________________

The following questions will help determine if there is any reason you should not receive a COVID immunization injection.
Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.

Question	No	Yes
Has the person to be vaccinated ever received a COVID-19 vaccine?	☐ No	☐Yes
If yes, date:________________ Type/Brand of COVID vaccine:_____________________		
Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex?	☐ No	☐Yes
List all allergies: ____		
Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy?	☐ No	☐Yes
Is the person to be vaccinated sick today?	☐ No	☐Yes
Is the person to be vaccinated at least 18 years old?	☐ No	☐Yes
Is the person to be vaccinated currently pregnant or Breastfeeding?	☐ No	☐Yes
Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner?	☐ No	☐Yes
Has the person to be vaccinated received any other vaccines in the past 14 days?	☐ No	☐Yes
Have you been treated for COVID-19 infection with convalescent plasma or monoclonal antibody therapy with the last 90 days?	☐ No	☐ Yes

☐ I have reviewed the COVID-19 vaccine Fact sheet for Recipients.
The Food and Drug Administration has recently issued an Emergency Use Authorization (EUA) for COVID-19 vaccine. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian). I release Comprehensive Internal Medicine and its employees any and all liabilities in connection with this vaccine and the administration to me.

I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

Print Parent/Guardian name, if different from client: ____

Client/Parent/Guardian Signature: ____Date: _____________

FOR CLINIC USE ONLY

Date vaccine administered: ____/____/_____ ***Date booster required***: ____/_____/_____ ***Site of IM injection RDT or LDT***

Vaccine Dose: ☐ Dose 1 ☐ Dose 2 ☐ Vaccine was entered in Practice Fusion and transmitted to GRITS

Signature and title of vaccine administrator: ____