



COVID Vaccine Consent Form

PLEASE PRINT LEGIBLY

Legal Name: _____

Lawson ID# _____ (St. Bernards Employees)

St. Bernards Department or Employer:

Position: _____

This is my:	
FIRST DOSE	SECOND DOSE
OF COVID VACCINE	
(CIRCLE ONE)	

1. Have you ever received any vaccination in the past? YES* NO
 * If yes, did you have any problems? YES* NO
 * If yes, what kind of problems? _____
2. Have you received any vaccination within the last 2 weeks? Yes No
3. Do you have another vaccination scheduled? (Other than this COVID vaccine series)
 YES NO
4. Have you received COVID 19 treatment with monoclonal antibodies or convalescent plasma with the last 90 days?
 YES NO
5. Do you have an allergies or reactions to any foods, medications, or vaccines?
 YES NO
6. In the past have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?
 YES NO
7. For females, are you pregnant, planning to become pregnant or breastfeeding? YES NO Not Applicable
8. Do you have a bleeding disorder or are you on a blood thinner? YES NO
9. Have you received a COVID-19 vaccine other than the initial Pfizer-BioNTech if this is your second dose?
 YES NO
10. Are you immunocompromised or are you on a medicine that affects your immune system?
 YES NO

(OVER)

CONSENT FOR VACCINATION:

I have been provided with the most current Fact Sheet for Recipients and Caregivers for the Emergency Use Authorization of the Pfizer-BioNTech COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) that explains the benefits and risks of receiving vaccination. As with all medical treatment, there is no guarantee that I will not experience an adverse side effect from the vaccine. I understand that if I receive one dose of the Pfizer-BioNTech COVID-19 Vaccine, I should receive a second dose of this same vaccine 3 weeks later to complete the vaccination series.

I request that the vaccine be given to me.

Legal Name:

(Printed)

Male: _____ Female: _____

Date of Birth: _____
(Month/Day/Year)

Race: _____

Hispanic _____ Not Hispanic/Latino _____

Address: _____

City: _____

State: _____

County: _____

Zip Code: _____

Phone: (____) _____ - _____

By providing St. Bernards with your phone number, you consent to St. Bernards or its agents contacting you via text message or phone call regarding your vaccines and/or vaccine appointments.

Signature: _____

Date: _____

Time: _____

HOSPITAL USE ONLY	
Manufacturer: Pfizer-BioNTech	
Lot#:	_____
Exp. Date:	_____
IM Injection Site: R deltoid	____
	L deltoid ____
Dose: 0.3 ml	
_____ Administering Provider Signature/Credential	
Date:	_____
Time:	_____

Parent/Legal Guardian Signature (required if under 18) _____
Relationship to patient _____