NH DIVISION OF Public Health Services
Department of Health and Human Services

Consent Form for Administration: COVID-19 Vaccination

Patient Name:_____**DOB**:_____**Age:**____**Street Address:**_____
Town/City:_____**State:**_____**County:**_____**Zip**:_____
Gender: ☐ Female ☐ Male ☐ Other ☐ Decline to Specify **Ethnicity:** ☐ Non-Hispanic ☐ Hispanic ☐ Unknown ☐ Decline to Specify
Race (Check all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown ☐ Decline to Specify

SCREENING QUESTIONS: PLEASE CHECK	**YES**	**NO**
Are you sick today? Or have you had any symptoms of COVID-19 including fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches? *(If yes do not vaccinate)*		
Have you ever had a serious reaction after receiving a vaccination including anaphylaxis? *(If yes, patient should consult with PCP first, monitor for 30 minutes post vaccination)*		
Have you had Guillain-Barre Syndrome? *(If yes, patient should consult with PCP first)*		
Are you pregnant/breastfeeding or is there a chance you could become pregnant? *(If yes, patient should consult with OB first)*		
Have you received any vaccinations in the past 4 weeks? (*okay to administer within 4 weeks of other vaccinations or same day as other vaccinations aside from alternative COVID-19 vaccines)*		
In the past two weeks, have you tested positive for COVID-19? (*If yes, patient should be fully recovered prior to receiving vaccine)*		
Do you have any allergies or reactions to any food, medications, vaccines or latex? *(If yes, patient should consider consult with PCP first, monitor for 30 minutes post* vaccination)		
Are you immunocompromised or on a medication that affects your immune system? (*If yes, patient should consult with PCP first)*		
Within the last 90 days, have you experienced an immune condition called thrombosis with thrombocytopenia (TTS) causing both clotting and low platelets? *(if yes, do not administer the Janssen* Vaccine unless patient attests to understanding known risks)		
Have you received a previous dose of any COVID-19 vaccinations? a. Is this your 3rd dose (BOOSTER)? YES / NO **(Booster Doses are Approved only for anyone >12y; only Pfizer for 12-17 year olds and immunocompromised 5-11yr old)** b. Have you attested to required criteria YES / NO c. Date of second vaccine:_____Pfizer / Moderna		
Are you between the ages of 5-11? If yes, only administer the Pfizer-BioNTech COVID-19 vaccine (*ORANGE CAP VIAL ONLY*)		
Have you received monoclonal antibodies in the last 90 days? *(If yes, do not vaccinate)*		

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

I hereby acknowledge the following: (please initial)

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

Consent and waiver: I consent to the administration of the Vaccine by ConvenientMD. I fully release and discharge ConvenientMD, 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/Parent or Guardian (If under the age of 18):_____**Date:** _____

Vaccine:_____ VIS/EUA Date:_____ Lot #:_____ Exp Date:_____Dose:_____

TEMP:_____ Site:_____ Date Given:_____Time Given_____Admin by/Title: _____