Sleepy Eye Medical Center – COVID-19 VACCINE CONSENT FORM 2020-2021
Information about the person to receive vaccine. Please Print

Last Name_____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Phone Number: _____

Family Physician: _____ Primary Clinic: _____

Allergies _____ Nurse Initials: _____

Please Answer the Following Screening for Vaccine Eligibility Questions:

1. Have you had a severe allergic reaction to previous dose of COVID-19 vaccine? (e.g. anaphylaxis) **If yes, please specify:**	Yes ❑ No ❑ Unknown ❑
2. Have you had a severe allergic reaction to a component of the COVID-19 vaccine?	Yes ❑ No ❑ Unknown ❑
3. Have you had severe allergic reaction (e.g. anaphylaxis) to any other vaccine or injectable therapy (e.g. intramuscular 'in the muscle', intravenous 'in the vein' or subcutaneous 'under the skin'?	Yes ❑ No ❑ Unknown ❑
4. Are you currently ill due to COVID-19?	Yes ❑ No ❑ Unknown ❑
5. Have you received monoclonal antibodies or convalescent plasma as part of treatment for COVID-19 in the past 90 days?	Yes ❑ No ❑ Unknown ❑
6. Are you currently exposed to another person with known COVID-19 disease?	Yes ❑ No ❑ Unknown ❑
7. Have you ever received a dose of COVID-19 vaccine? If yes, which of the following was provided: ❑Pfizer ❑Moderna ❑Astra Zeneca ❑Johnson & Johnson	Yes ❑ No ❑ Unknown ❑
8. If female, are you pregnant? If so, have you consulted with your provider?	Yes ❑ No ❑ N/A ❑ Yes ❑ No ❑ N/A ❑
9. Have you received any other vaccines (Not COVID-19) wtihin the past 14 days?	Yes ❑ No ❑ Unknown ❑

• I have read or had explained to me the COVID Vaccine Fact Sheet for recipients and caregivers. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the COVID vaccine and ask that the vaccine is to be given to me or to the person named above for whom I am authorized to make this request.

• I am aware that information collected on this form will be used to document that you have received vaccine(s). Immunization information may be shared through the Minnesota Immunization Information Connection with other health care providers, schools, health departments and other authorized under law to receive it. If you have any questions, please ask your health care provider. If you have questions about MIIC, refer to MIIC and the public (www.health.state.mn.us/people/immunize/miic/public.html) or call 1-800-657-3970.

Signature- Self/POA/Guardian: _____Date: _____

Administrative Use Only:	Vaccine Type: COVID-19.
Date Dose #1 Given: Month _____ Day _____ Year_____ Date Dose #2 Given: Month _____ Day _____ Year_____ **Signature of Vaccinator/Title:** _____	Manufacture: _____ Lot Number: _____ Site : IM – LD IM – RD EXP: _____ NDC: _____