COVID-19 Vaccination Form - Statement of Understanding, Permission & Assignment

Harnett County Department of Public Health

Last Name_____LEGAL FULL First Name_____Middle_____

Date of Birth:_____ Age in years:_____

Circle your Race: White Black American Indian/Alaskan Native Asian/Pacific Islander Other

Circle your ethnicity: Hispanic Non-Hispanic

Circle your Sex: Female Male Decline to say Other

County of Residence:_____

Street Address:_____

City_____ State_____ Zip Code_____

Home Phone #_____ Cell Phone #_____

Email:_____

Please circle all disabilities that may apply to you: NOT DISABLED CANCER COGNITIVE NEUROLOGICAL PHYSICAL RESPIRATORY SENSORY OTHER _____

Statement of Understanding: I have read and I understand the information provided to me about receiving the COVID-19 vaccine and I have had the opportunity to ask questions. I understand that the U.S. Food and Drug Administration (FDA) has issued an Emergency Use Authorization (EUA) to permit the emergency use of the unapproved product, for active immunization to prevent COVID-19 in individuals. The following questions will help us determine if there are any reason, you should not receive the vaccine today. Please answer all questions truthfully.

Notice of Privacy Practices: By signing below, I am acknowledging that:

- I am either the patient or the patient's personal representative
- The Notice of Privacy Practices for Harnett County Health Department has been made available to me
- I understand that I may contact the person named in the notice if I have questions about the content of the notice.

Please read all questions and answer:

1. Are you feeling sick today? **Yes** **No**

2. Have you ever received a dose of COVID-19 Vaccine? **Yes** **No**

****If yes, list date and brand:_____**

3. Have you had a serious allergic reaction to any components of the Moderna COVID-19 Vaccine, Pfizer COVID-19 vaccine, Janssen COVID-19 vaccine, polysorbate, polyethylene glycol, or a vaccine/injectable therapy that contains a COVID-19 component? (Each dose of the Moderna COVID-19 vaccine contains the following ingredients: a total lipid content of 1.93 mg (SM-102, polyethylene glycol (PEG) 2000(found in some medications such as laxatives and preparations for colonoscopy procedure), dimyristoyl glycerol (DMG), cholesterol, and 1, 2-distearoyl-sn-glycero-3-phosphocholine (DSPC), 0.31 mg tromethamine, 1.18 mg tromethamine hydrochloride, 0.043 mg acetic acid, 0.12 mg sodium acetate, and 43.5 mg sucrose).

(Each dose of the Pfizer vaccine contains the following ingredients: mRNA, lipids ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2 [(polyethylene glycol)-2000]-N,N-ditetradecylacetamide, 1,2-Distearoyl-sn-glycero-3-phosphocholine, and cholesterol), potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, and sucrose).

Each 0.5 mL dose of Janssen COVID-19 Vaccine is formulated to contain 5×1010 virus particles (VP) and the following inactive ingredients: citric acid monohydrate (0.14 mg), trisodium citrate dihydrate (2.02 mg), ethanol (2.04 mg), 2-hydroxypropyl-β-cyclodextrin (HBCD) (25.50 mg), polysorbate-80 (0.16 mg), sodium chloride (2.19 mg). Each dose may also contain residual amounts ofhost cell proteins (≤0.15mcg) and/or host cell DNA (≤3 ng).

Yes **No**

4. Have you ever had a severe allergic reaction (anaphylaxis) to something? (This includes vaccines, foods, pets, venom, environmental, or medication allergic reactions.) **Yes** **No**

5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? **Yes** **No**

6. Have you received another vaccine in the last 14 days? **Yes** **No**

7. Have you had a positive test for COVID-19 or has a doctor told you that you had COVID-19?

****If yes, when_____** **Yes** **No**

8. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? **Yes** **No**

9. Do you have a bleeding disorder or are you taking a blood thinner? **Yes** **No**

10. Are you pregnant or breastfeeding? **Yes** **No**

11. Do you have dermal fillers? **Yes** **No**

Statement of Permission & Assignment: By signing below, I voluntarily give my permission to receive a COVID-19 Vaccine. I understand no payments will be required from myself in regards to COVID-19 vaccination.

X_____ **X_____**

Signature **Date**

DO NOT WRITE BELOW THIS LINE

For Office Use Only: Circle one: **Pfizer** **Moderna** **Janssen** Circle one: **First Dose / Second Dose**

COVID-19 Vaccine Lot Number: _____ Injection Site (Circle one): **Right Deltoid / Left Deltoid**

Patient Given COVID-19 Vaccination card, COVID-19 Vaccine EUA and V-Safe Information: **Yes** **No**

Administered by:_____ Date:_____Time:_____

Printed Name:_____ **Registered in CVMS:** Yes No **Administration Entered:** Yes No