University of Rochester Medical Center
COVID-19 Vaccine Consent Form

For Office Use Only
☐ Entered into Agility _____ *(initials)*
☐ Entered into NYSIIS _____ *(initials)*

First Name (print):

Last Name (print):

Date of birth: Month Day Year

Dept/Unit: _____

Phone #: _____

If you select "Yes" for any of the following, it is recommended that you speak with your healthcare provider before receiving the COVID vaccine.	Yes	No
▪ Are you feeling sick today?	☐	☐
▪ In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	☐	☐
▪ Have you been treated with antibody therapy for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?*	☐	☐
▪ Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot?	☐	☐
▪ Have you had any vaccines in the last 14 days (2 weeks) including a flu shot? *If yes, how long ago was your most recent vaccine?*	☐	☐
▪ Are you pregnant or considering becoming pregnant?	☐	☐
▪ Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	☐	☐
▪ Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	☐	☐

I have been provided the FDA's Fact Sheet for Emergency Use Authorization (EUA) of the COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19).

I understand the benefits and potential risks of receiving this vaccine and have had the opportunity to ask questions. I consent to receive the COVID-19 vaccine. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

Signature: _____ Today's date: Month Day Year

For Vaccinator Use Only

COVID-19 vaccine given by:

Vaccinator Signature: _____ Print Name: _____ Date: Month Day Year

☐ **COVID-19** mRNA, LNP-S, PF, 30mcg/0.3 ml dose **Site:** ☐ **Rt Deltoid** ☐ **Lt Deltoid** **Mfg: Pfizer** **Lot #:** _____ **Exp. Date:** _____

☐ **COVID-19** mRNA, LNP-S, PF, 100mcg/0.5 ml dose **Site:** ☐ **Rt Deltoid** ☐ **Lt Deltoid** **Mfg: Moderna** **Lot #:** _____ **Exp. Date:** _____