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Athens City-County Health Department
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COVID-19 Consent Form

Athens City-County Health Department
278 W. Union St., Athens, OH 45701

Person Receiving Vaccine Demographic Information

Last Name	First Name	Middle Name
Date of Birth	Age	Phone #
Sex: Male Female Prefer Not to Say Other:		Country of Birth
Street Address City State Zip		
Primary Language ☐ English ☐ Other: ___________________________	Race ☐ White ☐ Asian ☐ Black/African American ☐ Native American/Alaskan Native ☐ Other	Ethnicity ☐ Hispanic ☐ Non Hispanic

Please answer the questions below for the person receiving the vaccine. **Yes** **No**

1. Are you feeling sick today? ☐ ☐
2. Have you ever had a severe allergic reaction to something? ☐ ☐
   (Ex. You had to be treated with an epinephrine, EpiPen, had to go to the hospital, or caused an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing)
3. Have you ever had a severe allergic reaction to another vaccine or an injectable therapy? ☐ ☐
4. Have you ever received a dose of COVID-19 vaccine? Which product: ________________ ☐ ☐
5. Do you have a history of myocarditis or pericaditis? ☐ ☐
6. Have you received passive antibody therapy for COVID-19 in the past 90 days? ☐ ☐
7. Have you ever been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection? ☐ ☐
8. Do you have a bleeding disorder or are you taking a blood thinner? ☐ ☐
9. Do you have a weakened immune system caused by HIV or cancer, or take immunosuppressive drugs? ☐ ☐
10. Have you ever had Guillain-Barré syndrome? ☐ ☐
11. Do you have a history of heparin-induced thrombocytopenia (HIT)? ☐ ☐
12. Have you received dermal fillers? ☐ ☐
13. **For women:** Are you pregnant, is there a chance that you could be pregnant, or are you breastfeeding? ☐ ☐

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I acknowledge that I have been offered a copy of the Athens City-County Health Department's (ACCHD) Notice of Privacy Practices. A copy of the Emergency Use Authorization (EUA) has been provided. I have read, or have had explained, the information about the disease(s) and vaccine(s) listed. I had an opportunity to ask questions and believe that I understand the benefits and/or risks of the vaccine(s). I consent to the administration of the vaccines listed to be given to the person named above and I am authorized to give this consent. I agree to the electronic transmission of immunizations and other information on this form to the Ohio Department of Health's Immunization Registry.

I authorize ACCHD to release service related information regarding the above mentioned person to third party payers of bill for service(s) rendered to me. I request my payer pay ACCHD direcoty for services rendered to me.

____ ________________________

SIGNATURE OF CLIENT or Person Authorized to Sign on the Client's Behalf **DATE**

--------------------OFFICE USE ONLY--------------------

CPT	Vaccine to be Given	Lot Number	Mfr	Vaccine Info Fact Sheet Date	Admin Site	Route	Amount
	COVID-19	FD8448	Pfizer	08/23/21	RD / LD	IM	.3 ml

Nursing Assessment Per Prevaccination Checklist for COVID-19 Vaccines/Teaching/Vaccine Administration:

___________________________RN ____________________ ________________

Signature **Date of Vaccine** **Time**