INFORMED CONSENT –
COVID-19 Vaccine

Employee: ☐

Before you receive the Vaccine, please read the **attached Fact Sheet for Recipients and Caregivers ("Fact Sheet")** and talk to your health care provider about any questions or concerns you might have. You have the option to accept or refuse the Vaccine.

Please complete the following:	**Circle One**	
Are you 18yrs of age or older?	Y	N
Are you currently sick or running a fever greater 100.4?	Y	N
Do you have a bleeding disorder or are you on a blood thinner?	Y	N
Are you immunocompromised or are you on a medicine that affects your immune system?	Y	N
Have you had a severe allergic reaction to any component of the vaccine?	Y	N
Have you ever had a severe allergic reaction (lightheadedness, recurrent emesis, etc.) to any medication, vaccine and/ or latex that may have required epinephrine or other emergency medical intervention?	Y	N
Are you breastfeeding, pregnant or planning to become pregnant?	Y	N
Have you received any vaccination in the last 14 days?	Y	N
Have you had a confirmed positive case of COVID-19 in the past 90 days?	Y	N
Have you received another COVID-19 vaccine?	Y	N
Do you have any of the following illnesses or conditions? Chronic lung disease (including asthma), heart disease, diabetes, brain spinal cord or muscle illness that causes swallowing or lung problems, problems with the immune system caused by medication and/ or HIV, kidney disease, blood disorders.	Y	N

Authorization to administer vaccine:
I have answered the above questions truthfully. I have received and understand the vaccine fact sheet including the potential risks and benefits of receiving the vaccine. I have had a chance to ask questions, which were answered to my satisfaction. I hereby release this provider, its employees and its volunteers from any liability for any results which may occur from the administration of this vaccine.

_____ _____
Recipient Name (print) Date of Birth

_____ _____
Parent/ Guardian/ Caregiver Name (if different than recipient) Relationship to recipient

_____ _____
Signature Date

For Grand River Health use only:

Initial Dose	Date:	**Booster Dose**	Date:
Manufacturer/NDC:			
Lot#: _____ Site: LUA RUA	Exp:_____ Route: IM	Lot#: _____ Site: LUA RUA	Exp:_____ Route: IM
Vaccine Given By:		Vaccine Given By:	

[Attach Fact Sheet for Recipients and Caregivers]

CIIS_____ Note_____

CIIS_____ Note_____

Recipient Personal Information – All information will be kept confidential

Last Name	First Name	MI	Date of birth	Gender (Male / Female)

Mailing Address	Physical Address (if different than mailing address)

City	County	State	Zip

Phone # Cell or Home