COVID-19 Vaccine Screening and Consent

Please complete the following: **Circle One**

Question		
Are you or your child sick today or have a fever?	Y	N
Have you or your child had an allergic reaction to a previous dose of COVID-19 vaccine?	Y	N
Have you or your child ever had a serious allergic reaction (anaphylaxis) to another vaccine or any injectable medication?	Y	N
Have you or your child ever had a serious allergic reaction (anaphylaxis) to foods, pets, venom, environmental or oral medications?	Y	N
Do you or your child have a bleeding disorder, are on long term aspirin therapy, or take other blood thinners?	Y	N
Have you or your child ever had Guillain-Barre Syndrome after receiving a vaccine?	Y	N
Have you or your child had convalescent plasma or monoclonal antibodies as part of COVID-19 treatment in the past 3 months?	Y	N
Have you received dermal fillers?	Y	N
Do you or your child have a history of myocarditis or pericarditis?	Y	N
Do you or your child have a history of Multisystem Inflammatory Syndrome known as MIS-C in children or MIS-A in adults after a COVID-19 infection?	Y	N
Do you or your child have a history of Heparin-induced thrombocytopenia (HIT)?	Y	N
Do you or your child have a weakened immune system or have had a solid organ transplant?	Y	N
Do you or your child take immunosuppressive drugs or therapies?	Y	N
Are you at increased risk for COVID-19 because of where you work or live? (Applies to adults age 18-64)	Y	N

Are you a Grand River Employee **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

Applies to
Pfizer Vaccine – age 5 and over
Moderna vaccine – age 18 and over

Recipient Personal Information – All information will be kept confidential

_______________________________________ _________________________________ _____ _______________

Last Name First Name MI Date of birth

Male Female Transgender Female/Feminine Transgender Male/Masculine Non-Binary

Decline

Unknown

____ ____

Mailing Address Physical Address (if different than mailing address)

____ ______________________________ ___________ ____________________

City County State Zip

Phone# ______________________________________

For Grand River use only:

Initial Dose	Date:	**Second Dose**	Date:	**Booster________** **Additional Dose______**	Date:
Manufacturer/Lot #		Manufacturer/Lot #		Manufacturer/Lot #	
Site: **LUA RUA**	Route: IM	Site: **LUA RUA**	Route: IM	Site: **LUA RUA**	Route: IM
Vaccine Given By:		Vaccine Given By:		Vaccine Given By:	