North Central Health Care
Person centered. Outcome focused.

Vaccination Consent Form

First Name: _____
Middle Initial: _____
Last Name: _____
DOB: _____
Please Print Clearly

Please initial next each vaccine if you CONSENT to or DECLINE the vaccine.

Vaccination	I CONSENT to have	I DECLINE to have
COVID Vaccine (to meet most recent guidelines)		
Influenza, Annual Vaccination		

Nurse to Complete Below Questions at Time of Administration

YES	NO	Screening Questions for ALL Vaccinations: Please answer the following questions:
		Do you currently have an acute illness or infection?
		Are you on anticoagulant therapy or do you have a bleeding disorder?
		Do you have a severe allergy to latex?
		Are you allergic to eggs or egg products?
		Are you allergic to thimerosal (a preservative) other than contact lens sensitivity?
		Have you had a systemic allergic reaction, any adverse reaction, seizure, Guillain-Barre syndrome, coma or encephalopathy related to a previous vaccine? List Allergy: _____
		Do you have any other allergies? *(A "yes" response would not be an exclusion form COVID-19 Vaccination)* List Allergy: _____
		Do you currently have a progressive or unstable neurologic or uncontrolled seizure disorder?
		Have you been given the Vaccine Information Statement for the vaccines?

If answered Yes to any of the above questions, with the exception of the last one, consult with the provider about administrating the vaccine.

***Note:** not all vaccines should be given at once. Vaccines should be spaced based on CDC recommendations.*

COVID-19 Vaccination Questions Only	
Already Vaccinated: ☐ I have already been vaccinated against COVID-19. **Please Provide Proof**.	Provider Name: _____ Date of Vaccination: _____ Dose received: ☐ Moderna ☐ Pfizer ☐ Other _____

COVID Vaccine – Administrative Use Only	
Name of Vaccine: *☐ COVID-19 Vaccine*	
Date Administered: _____/_____/_____	*Date VIS Fact Sheet Provided: _____/_____/_____*
Vaccine Manufacturer: *☐ Moderna ☐ Pfizer*	*Lot #: _____* *Exp Date: _____/_____/_____*
Administration Site: *☐ Left Deltoid ☐ Right Deltoid*	*Dose: 0.5 ml*
Name and Title of Vaccine Administer: _____	
Date WIR Entry Completed: _____/_____/_____ (Must be Entered within 24 hours)	