LITTLE BIG HEALTH SOLUTIONS

COVID-19 Vaccination Consent Form

Patient Name (**First/MI/Last**): ____

Birth Date (mm/dd/yyyy): ______/______/_____ **Age:** ______ **Gender**: Male ☐ Female ☐ Other: _______

Race: White☐ Black☐ Asian☐ Indian☐ Native American/Alaska Native☐ Hispanic: Yes ☐ No☐

Address: ____

City/State/Zip: ____

Phone: ______________________________ Email: ____

Please answer all questions below:

	Question	*Yes*	*No*	*N/A*
1.	Are you feeling sick today?			
2.	Have you ever received a dose of COVID-19 vaccine?			
	• If yes, which vaccine product did you receive? Johnson & Johnson ☐ Moderna ☐ Pfizer ☐ Another product: _________________ How many doses have you received? ____________________________________			
3.	Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], DiGeorge syndrome or Wiskott-Aldrich syndrome)*			
4.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to a previous dose of this vaccine, another vaccine, or other substances that resulted in any of the following: • Treatment with epinephrine/EpiPen® or a trip to the hospital? • Hives, swelling, or respiratory distress, including wheezing, within 4 hours of exposure?			
5.	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			

By signing this form, I request and voluntarily consent for the COVID-19 vaccine to be administered to ____________________________ (self or name of child for whom I am the Parent/Legal Guardian) and a record of the vaccination be entered into a database for use to monitor the administration of the vaccine and the control of the disease. Further, I agree that the information above is correct, and: (i) I have been offered the U.S. Food and Drug Administration's Emergency Use Authorization (EUA) Fact Sheet For Recipients and Caregivers (Fact Sheet); (ii) I understand the risks and benefits of being administered the COVID-19 vaccine and that possible side effects, warnings, and precautions should be considered prior to the administration of the vaccine; (iii) any questions I had about the COVID-19 vaccine and the EUA Fact Sheet have been answered; and (iv) I acknowledge that no guarantees have been made concerning the vaccine's success.

Signature: ____ Date: ______________________

For Clinic Staff Use:

PA SIIS ID#	Date Administered	Vaccine Brand	Vaccine Dose (ml)	Lot #	Site / Route	Dose #	Vaccinator Signature

Warwick Square ☐ Neshaminy Mall ☐ Other: __________