COMPLETE AND BRING WITH YOU TO SCHEDULED VACCINATION APPOINTMENT

COVID-19 Vaccine Consent Form

Section 1: Information about Person to Receive Vaccine (please print)

Name: Date of Birth: Age: Sex (circle): M F	
Race (circle): White / Black or African American / Asian / American Indian or Alaska Native / Other Pacific Islander	Ethnicity (circle): Non Hispanic / Hispanic Email:
Address:	Previous name(s):
City/State/Zip:	Phone:

Section 2: Screening for Vaccine Eligibility

Has this person been vaccinated with the COVID-19 vaccine? (circle) YES NO Doses: 0 1 2

Section 3: Consent

I understand I either have or will receive the Emergency Use Authorization (EUA) fact sheet prior to the administration of the vaccine and have the ability to revoke consent at any time.

REQUIRED PARENT/GUARDIAN INFORMATION

First Name: _____ **Middle:** _____ **Last Name:** _____

Sex (circle): Male Female **Date of Birth:** ____/____/_____ **Phone Number:** (____)_____-_____

Street Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Your signature indicates that you give consent to LLCHD and its staff for the person named at the top of this form to be vaccinated with this vaccine.

Client Signature OR Signature of Parent/Legal Guardian

X_____ Relationship_____

Date: Month_____ Day_____ Year_____

DO NOT WRITE BELOW THIS LINE: OFFICE USE ONLY

Section 4: Vaccine Administration Record

Injection Site (Deltoid) please circle: Left Right

Manufacturer: Pfizer Moderna AstraZeneca Johnson & Johnson

Lot#:_____ Exp:_____

The vaccine administrator's signature below attests that the vaccine recipient's identity has been confirmed and that the vaccine recipient has been properly screened according to the CDC guidelines and recommendations.

Vaccine Administrator (signature):

X_____ Date: _____

Prevaccination Checklist for COVID-19 Vaccination

Name _____

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. How old are you? _____			
2. Are you feeling sick today?	☐	☐	☐
3. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product(s) did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	☐	☐	
4. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *This would include, but not limited to, treatment for cancer, HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.*	☐	☐	☐
5. Have you received COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies?	☐	☐	☐
6. Have you ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
7. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

8. Check all that apply to you:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Have a history of Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?
- ☐ History of an immune-mediated syndrome defined by thrombosis and thrombocytopenia, such as heparin-induced thrombocytopenia (HIT)
- ☐ Have a history of thrombosis with thrombocytopenia syndrome (TTS)
- ☐ Have a history of Guillain-Barré Syndrome (GBS)
- ☐ Have a history of COVID-19 disease within the past 3 months?

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists

CITY OF LINCOLN NEBRASKA
LINCOLN-LANCASTER COUNTY HEALTH DEPARTMENT
3131 "O" Street Lincoln, NE 68510-1514
402-441-8000 TDD: 402-441-6284 fax: 402-441-6229
LANCASTER COUNTY NEBRASKA
lincoln.ne.gov

AUTHORIZED CONSENT AND APPOINTMENT OF AGENT

I authorize the nurses and/or physician of Lincoln-Lancaster County Health Department to carry out any medical order, examine, immunize, and/or test my child, _____, in my absence in accordance with the Health Department's schedules and policies, which I have authorized in writing.

Further, I hereby appoint_____(adult 19 years or over), as my agent and representative for the purpose of authorizing and consenting to hospital care and/or medical care of the above-named child for any reaction to medicine, illness or injury while such person is in the care of the agency and when I am not immediately available to give such consent.

Allergies: _____

Family Physician: _____

Physician Phone: _____

Dated this_____day of_____20_____

_____
Parent or Guardian Printed Name

_____
Parent or Guardian Signature

_____
Address

_____
Phone

This statement can be revoked in writing at any time and expires in any event 60 days after it is signed.

Revised 12/2021

EXAMPLE PACKET PAGE 1

COMPLETE AND BRING WITH YOU TO SCHEDULED VACCINATION APPOINTMENT

COVID-19 Vaccine Consent Form

Section 1: Information about Person to Receive Vaccine (please print)

Name: MINOR'S NAME Date of Birth: 06/01/2004 Age: 16 Sex (circle): M (F)

Race (circle): (White) / Black or African American / Asian / American Indian or Alaska Native / Other Pacific Islander

Ethnicity (circle): Non Hispanic / (Hispanic)

Email: PARENT/GUARDIAN'S EMAIL

Address: HOME ADDRESS

Previous name(s):

City/State/Zip: LINCOLN, NE 68510

Phone: PARENT/GUARDIAN'S PHONE

Section 2: Screening for Vaccine Eligibility

Has this person been vaccinated with the COVID-19 vaccine? (circle) (YES) NO Doses: 0 (1) 2

Section 3: Consent

I understand I either have or will receive the Emergency Use Authorization (EUA) fact sheet prior to the administration of the vaccine and have the ability to revoke consent at any time.

REQUIRED PARENT/GUARDIAN INFORMATION

First Name: PARENT/GUARDIAN FIRST NAME **Middle:** PARENT/GUARDIAN MIDDLE NAME **Last Name:** PARENT/GUARDIAN LAST NAME

Sex (circle): Male (Female) **Date of Birth:** PARENT/GUARDIAN DATE OF BIRTH **Phone Number:** (____)_____-_____ PARENT/GUARDIAN PHONE NUMBER

Street Address: PARENT/GUARDIAN PHYSICAL ADDRESS INCLUDING CITY, STATE, AND ZIP CODE **City:** _____ **State:** _____ **ZIP:** _____

Your signature indicates that you give consent to LLCHD and its staff for the person named at the top of this form to be vaccinated with this vaccine.

Client Signature OR Signature of Parent/Legal Guardian

X PARENT/GUARDIAN SIGNATURE Relationship RELATIONSHIP TO MINOR CHILD

Date: Month MONTH SIGNED Day DAY SIGNED Year YEAR SIGNED

DO NOT WRITE BELOW THIS LINE: OFFICE USE ONLY

Section 4: Vaccine Administration Record

Injection Site (Deltoid) please circle: Left Right

Manufacturer: Pfizer Moderna AstraZeneca Johnson & Johnson

Lot#:_____ Exp:_____

The vaccine administrator's signature below attests that the vaccine recipient's identity has been confirmed and that the vaccine recipient has been properly screened according to the CDC guidelines and recommendations.

Vaccine Administrator (signature):

X_____ Date: _____

MINORS MUST BRING COMPLETED FORM TO SCHEDULED APPOINTMENT

EXAMPLE PACKET PAGE 2

Prevaccination Checklist for COVID-19 Vaccination

For vaccine recipients:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

Name MINOR'S FULL LEGAL NAME

Age MINOR'S AGE ON DATE OF VACCINE

PARENT/GUARDIAN PLEASE COMPLETE ALL QUESTIONS BELOW

	Yes	No	Don't know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
• If yes, which vaccine product(s) did you receive? ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another Product _____			
• How many doses of COVID-19 vaccine have you received? _____			
• Did you bring your vaccination record card or other documentation?	☐	☐	
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 received hematopoietic cell transplant (HCT) or CAR-T-cell therapies since receiving COVID-19 vaccine?	☐	☐	☐
5. Have you ever had an allergic reaction to: *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of a COVID-19 vaccine, including either of the following:			
○ Polyethylene glycol *(PEG)*, which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐
6. Have you ever had an allergic reaction to another vaccine *(other than COVID-19 vaccine)* or an injectable medication? *(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)*	☐	☐	☐

7. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Have been treated with monoclonal antibodies or convalescent serum to prevent or treat COVID-19
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ Have a history of Guillain-Barré Syndrome (GBS)

Parent/Guardian Signature (if minor) PARENT/GUARDIAN SIGNATURE **Date** DATE SIGNED

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists

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LANCASTER COUNTY NEBRASKA
lincoln.ne.gov

AUTHORIZED CONSENT AND APPOINTMENT OF AGENT

ITEMS IN BOLD ARE REQUIRED, OTHERWISE, PLEASE BE AS THOROUGH AS POSSIBLE

I authorize the nurses and/or physician of Lincoln-Lancaster County Health Department to carry out any medical order, examine, immunize and/or test my child, _____CHILD'S FULL LEGAL NAME_____, in my absence in accordance with the Health Department's schedules and policies, which I have authorized in writing.

Further, I hereby appoint _____AUTHORIZED AGENT FULL NAME_____ (adult 19 years or over), as my agent and representative for the purpose of authorizing and consenting to hospital care and/or medical care of the above-named child for any reaction to medicine, illness or injury while such person is in the care of the agency and when I am not immediately available to give such consent.

Allergies: _____IF NONE, WRITE N/A OR NONE_____

Family Physician: _____IF NONE, WRITE N/A OR NONE_____

Physician Phone: _____PHONE NUMBER OF FAMILY PHYSICIAN_____

DATE OF SIGNATURE, WITHIN 60 DAYS OF APPOINTMENT

Dated this _____ day of _____ 20_____

PARENT/GUARDIAN PRINTED NAME

Parent or Guardian Printed Name

PARENT/GUARDIAN SIGNATURE

Parent or Guardian Signature

HOME ADDRESS

Address

PARENT/GUARDIAN PHONE NUMBER

Phone

This statement can be revoked in writing at any time and expires in any event 60 days after it is signed.

Revised 12/2021

LINCOLN LANCASTER COUNTY HEALTH DEPARTMENT

DEVELOPMENT SERVICES CENTER DSC