PIONEERS
MEMORIAL HEALTHCARE DISTRICT

COVID-19 Vaccine Consent

(Please Print Clearly)

Name:		**Date of Birth:**
☐ **Community Member** ☐ **Clinic Patient**		**Telephone:**
******************Complete the following (for CDC reporting requirements)*********************		
Address:		**Social Security:**
Race:☐Hispanic ☐Non-Hispanic ☐Unknown	**Ethnicity:** ☐Asian ☐Black ☐Indian ☐National Hawaiian/Pacific Islander ☐Other ☐ Unknown ☐White	**Sex:** ☐Male ☐Female

****Provide community member/patient with EUA (Emergency Use Authorization) and review any possible contraindications, side effect, precautions*****

☐ **Yes, I consent to receive the COVID vaccination**

☐ **NOT able to** receive the COVID-19 vaccine due to a contraindication:

- ☐ Anaphylactic Reaction
- ☐ Received other vaccine in past 14 days
- ☐ Received monoclonal antibodies or convalescent plasma in past 90 day

☐ Pregnant, breastfeeding, or planning to become pregnant (provide with ACOG Recommendations)

X

Signature **Date**

Dose #1

Vaccine Manufacturer: Lot #: Expires:

Site: ☐ Left deltoid ☐ Right deltoid Dose: ________ EUA Fact Sheet 12/2020

Signature: (**RN / LVN**) Date:

References:
EUA (Emerency Use Authorization Sheet) 12/2020
Cal-OSHA ATD Standard