NORTHBAY™ HEALTHCARE
1200 B. Gale Wilson Blvd., Fairfield, CA 94533 (707) 646-4000

Consent to Administer the COVID Vaccine

I have read or have had explained to me the Emergency Use Authorization (EUA) for administration of the COVID-19 vaccine. I have been given the opportunity to ask a health care professional questions concerning the vaccine. All of my questions concerning the vaccine have been answered to my satisfaction. I understand the benefits and risks of the COVID-19 vaccine and request that it be given to me. For current COVID-19 vaccines, two intramuscular doses are needed to see the reported benefits of these vaccines.

What should you mention to your Vaccination Provider before you get the COVID-19 Vaccine?

Tell the vaccination provider about all of your medical conditions, including if you:

Yes	No	
☐	☐	Have any allergies
☐	☐	Have a fever
☐	☐	Have a bleeding disorder or are on a blood thinner
☐	☐	Are immunocompromised or are on a medicine that affects your immune system
☐	☐	Are pregnant or plan to become pregnant
☐	☐	Are breastfeeding
☐	☐	Have received any other vaccine within 14 days of a COVID vaccine dose
☐	☐	Have tested positive for COVID in the last 90 days
☐	☐	Have received any COVID positive antibody treatments such as bamlanivimab, Regeneron, Casirivimab/Imdevimab or convalescent plasma therapy. **If yes, then must delay vaccine for 90 days after antibody treatments.**

***Please initial each statement below and complete the information at the bottom of the form:**

___☐ Initial I have received a copy and have read the detailed Emergency Agreement (EUA) produced by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Immunization Program which lists the benefits and risks of receiving the vaccine.

___☐ Initial I do not have a fever or flu-like symptoms

___☐ Initial I understand that if I have any questions or concerns regarding the vaccine, including whether or not to receive it, I should discuss them with a healthcare provider and receive the vaccine at a later date.

___☐ Initial I consent to release my immunization status to my primary care physician if assigned to NorthBay Health.

Initial PCP: _____

Please check one: ☐ NorthBay Employee ☐ Physician ☐ Volunteer Student ☐ Contractor ☐ EMS ☐ Board Member ☐ Other _____

Last Name (print) | First Name | Northbay Badge# | Phone Number | Date of Birth

☐ Hispanic/Latino
☐ Non-Hispanic/Latino

Race | Ethnicity | Email Address | City | Zip Code | Gender

Signature of person receiving the vaccine | Date | Time | Mother's First Name

Physician's Order:

Rx: Based on availability, administer either
☐ Pfizer vaccine (BNT162b2)30mcg/0.3mL IM now
☐ Moderna vaccine (mRNA-1283) 100mcg/0.5mL IM now

Physician Signature:  Yolanta Petrofsky, MD Date: _____

Pt. Allergies? ☐ No ☐ Yes - Specify_____

Location: ☐ NBMC ☐ VVH ☐ Employee Health ☐ Primary Care: Green Valley, Fairfield, Vacaville ☐ Other _____

Lot# _____ Exp. Date: _____ Manufacturer: _____

Injection site: ☐ R Deltoid ☐ L Deltoid ☐ Other (Specify) _____

Administered By: Name: _____ Date: _____ Time:_____

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