

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 | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have any allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Have a fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Have a bleeding disorder or are on a blood thinner |
| <input type="checkbox"/> | <input type="checkbox"/> | Are immunocompromised or are on a medicine that affects your immune system |
| <input type="checkbox"/> | <input type="checkbox"/> | Are pregnant or plan to become pregnant |
| <input type="checkbox"/> | <input type="checkbox"/> | Are breastfeeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Have received any other vaccine within 14 days of a COVID vaccine dose |
| <input type="checkbox"/> | <input type="checkbox"/> | Have tested positive for COVID in the last 90 days |
| <input type="checkbox"/> | <input type="checkbox"/> | 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:**

- 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.
- I do not have a fever or flu-like symptoms
- 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.
- I consent to release my immunization status to my primary care physician if assigned to NorthBay Health.

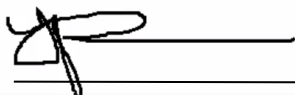
Initial PCP: _____

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
<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino				
Race	Ethnicity	Email Address	City	Zip Code
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: _____