Clear Form Print Form

Consent to Administer the COVID-19 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.

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 or anaphylaxis- (list allergies)
☐	☐	have a bleeding disorder or are on a blood thinner
☐	☐	immunocompromised or are on a medicine that affects your immune system
☐	☐	are pregnant or plan to become pregnant
☐	☐	are breastfeeding
☐	☐	have received another COVID-19 vaccine or any other vaccine in the past 2 weeks

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

_____ I have reviewed the Emergency Use Authorization (EUA), produced by the U.S.Department of Health and Human Services, Centers for Disease Control (CDC) and 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 understand that I will need to continue to follow precautions such as masking, distancing and cleaning as per the Cal Maritime COVID-19 Health and Safety plan.

Cal Maritime will only release your immunization status to Solano Public Health.

PLEASE PRINT CLEARLY BELOW

(Last, First, MI)	*Date of Birth (mm/dd/yyyy)*	*Phone No. (Mobile)*

_____ _____

Signature of Person Receiving the Vaccine *Date*

Provider to fill out below-

Patient Allergies confirmed? ☐ No ☐ Yes, specify _____

Location of vaccination:_____

Lot#: _____ Exp. Date: _____ Manufacturer: _____

Administer: _____

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

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