First Dose _____ Second Dose_____ Third Dose_____ SPLASH ID_____

COVID-19 Vaccine Consent Form

PRINT NAME _____DOB_____CELL NUMBER_____

DEPARTMENT/SPECIALTY_____TITLE_____ Phone number_____

NAME OF EMPLOYER (For contractors) _____

PLEASE CHECK ANY THAT APPLY AND NOTIFY THE NURSE PRIOR TO ADMINISTRATION
If you answer yes to any of the questions, you should discuss with your physician before receiving the vaccine.

YES	NO	
☐	☐	Do you currently have a moderate or severe acute illness with or without fever (>100.0)?
☐	☐	Are you experiencing any COVID-like symptoms including but not limited to shortness of breath, dry cough, runny nose, sore throat, muscle pain, or loss of taste or smell?
		Do you have a bleeding disorder or are on a blood thinner?
☐	☐	Do you have a history of a HIV or an immunocompromising condition or take immunosuppressive medications?
☐	☐	Have you been administered monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the last 90 days?
☐	☐	Have you received any vaccinations in the past 14 days?
☐	☐	**For Women:** Are you pregnant or breastfeeding or is there a chance you could become pregnant during the next month?
☐	☐	Do you have a history of allergic reactions to vaccines, medicine, or food, such as an anaphylactoid reaction, or have you been advised to carry an adrenaline autoinjector with you (Epipen)?

I have received a copy of the ***Emergency Use Authorization of the COVID-19 Vaccine Fact Sheet for Recipients and Caregivers*** about the COVID-19 vaccine and have had a chance to ask questions and had them answered to my satisfaction.

I understand that the common side effects for adults include soreness and redness at the injection site, chills, fever, muscle aches, joint pain, muscle pain, headaches, nausea, swollen lymph nodes and tiredness.

There is a remote chance of more severe allergic reaction such as difficulty breathing, swelling of your face or throat, fast heartbeat, rash over your body or dizziness and weakness. There is the possibility that additional risks of the vaccine may exist that are not known at this time.

IF YOU EXPERIENCE A SEVERE REACTION, CALL 911 OR GO TO THE NEAREST HOSPITAL

Contact Tulane Living Well clinic at 504-988-4325 and your primary care provider to report side effects. Also report side effects to the FDA/CDC through the Vaccine Adverse Event Reporting System (VAERS) or through the V-Safe smartphone tool.

I give my permission to release this COVID-19 documentation to other medical care providers to avoid unnecessary vaccinations and to determine immunization status. When notified of moderate to significant adverse side effects that occur, Tulane will report your condition to the CDC and Louisiana Department of Health.

I understand that I am to wait **15 minutes (30minutes if previous reaction to a vaccine has occurred)** after receiving the COVID-19 vaccine before leaving the building.

I understand that I will need to return for a second injection and that the second dose is important for my protection to maximize immunity.

I understand the benefits and risks of the COVID-19 vaccine and I hereby authorize and consent to receive the vaccination.

Signature _____ Date_____

VACCINE NAME:	IMMUNIZATION LOT # & EXPIRATION DATE	DOSE GIVEN	INJECTION SITE/ ROUTE	DATE	TIME	VACCINE ADMINISTRATOR SIGNATURE
COVID-19 Manufacturer			R / L IM			