Consent for COVID-19 Vaccination

SECTION A Please print clearly.

First name: _____ Last name: _____

Date of birth: _____ Age: _____ Sex: _____ Phone: _____

Home address: _____ City: _____

State: _____ ZIP code:_____ Email address: _____

Primary Language: _____ Race: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

SECTION B The following questions will help to determine your eligibility to be vaccinated today.

1. Do you feel sick today? ☐ Yes ☐ No ☐ Don't know
2. Do you have any health conditions, such as heart disease, diabetes or asthma? If yes, please list: _____ ☐ Yes ☐ No ☐ Don't know
3. Do you have allergies to latex, medications, food or vaccines? If yes, please list: ☐ Yes ☐ No ☐ Don't know
4. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy? ☐ Yes ☐ No ☐ Don't know
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barre syndrome (a condition that causes paralysis) or other nervous system problem? ☐ Yes ☐ No ☐ Don't know

SECTION C

I certify that I am: (a) that patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the City of New Orleans Health Department and the licensed healthcare professional administering the vaccine to administer the COVID-19 vaccine. I understand that it is not possible to predict all possible side effects or complications associated with receiving the vaccine. I understand the risks and benefits associated with the vaccine and have received, read and/or had explained to me the vaccine information. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of myself, my heirs and personal representatives; I hereby release and hold harmless each Provider; its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the COVID-19 vaccine. I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("state Registry") and my state's health information exchange ("State HIE"); and (b) the Provider may disclose my vaccination information to the State Registry; to the State HIE; or through the State HIE to the State Registry, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my vaccination information to or through the State HIE as required or permitted by law. I also authorize the Provider to disclose my, or my child's proof of vaccination to the school where I am, or my child is a student or prospective student.

☐ **I want to receive the COVID-19 vaccine and I verify that I meet the current eligibility criteria.**

Patient Name:_____ Date:____7/29/21_____
(Parent or guardian, if minor)

Patient Signature:_____ Date:___7/29/21_____
(Parent or guardian, if minor)

SECTION D HEALTHCARE PROVIDER ONLY

Complete BEFORE vaccine administration

1. I have reviewed the **Patient Information** and **Screening Questions**. Initial here: _____

2. This vaccine is appropriate for this patient based on the **current LDH eligibility guidelines** provided by federal and/or state regulations and company policies. Initial here: _____

3. Does this patient have a **high-risk medical condition**?
   If yes, please list medical condition(s): _____ Initial here: _____

Lot #: ____ER8731_____ Expiration Date: _____7/31/21_____

SECTION E

Complete DURING the patient interaction

1. I have asked the patient to confirm their Name and DOB and verified it matches the information on the VAR form. Initial here: _____

2. I have reviewed the Screening Questions with the patient. Initial here: _____

SECTION F

Complete AFTER vaccine administration

Manufacturer	Dosage	Site of Administration (circle one)
Pfizer	0.3 mL	Right or Left Arm

Clinician's name (print): _____ Clinician's Signature: _____

Title: _____ Administration Date: _____

Notes

Reminder

1. Input information into the LaLINKS:
   a. Once entered, data entry person initials here _____