Soledad Medical Clinic

COVID-19 Vaccine Administration and Informed Consent

Last Name: _____ **First Name:** _____

- By signing this legal document, I certify that I am of legal age (18+); the legal guardian of the patient; or a person authorized to consent on behalf of the patient who is not otherwise able to give consent for themselves. I have been provided with and/or had explained to me the risks and benefits associated with the vaccine I am to receive and have been provided with Emergency Use Authorization Information (EUA). I understand that it is not possible to predict all possible side effects or complications associated with the vaccine I am receiving. I have been advised to remain on site for 15 minutes after administration to be observed for possible reactions to the vaccine.

- I understand that my vaccine information may be submitted to the state registry and shared with authorized health departments such as the Department of Health and Human Services and the Center for Disease Control and Prevention. I herby release the Soledad Health Care District (SHCD), Soledad Medical Clinic, its employees, and any connected business associates of the SHCD 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 vaccine listed above.

☐ **I have chosen to receive the COVID-19 vaccination series.**

- I have been given ample time and the opportunity to ask questions regarding the risks and benefits of the COVID-19 vaccine.
- I understand that I will continue to wear personal protection equipment (PPE) and continue to practice social distancing as mandated and upheld by the state of California.
- I understand that my insurance will be billed for services provided. However anything my insurance does not cover I will be responsible for.

Patient/Guardian Signature: _____ **Date:** _____

Soledad Medical Clinic
600 Main Street - Soledad, CA 93960
Phone: (831)678-2665
Fax: (831)678-2022

Patient Name: _____ **Date of Birth:** _____

COVID-19 PRE-VACCINATION ASSESSMENT		
If "YES" to any of 2-8, *DO NOT VACCINATE*	**YES**	**NO**
1. Are you younger than 18 years?	☐	☐
2. Have you had a severe allergic reaction of anaphylaxis to any component of the COVID-19 vaccine?	☐	☐
3. Have you received COVID-19 monoclonal antibody or convalescent plasma treatments within the last 90 days?	☐	☐
4. Do you have a fever of 100.5 degrees Fahrenheit or are you moderately or severely ill today?	☐	☐
5. Are you currently quarantining for COVID-19?	☐	☐
6. Have you received any other vaccines within the the past 14 days?	☐	☐
If "YES" to any of questions 7-9, patient review and acknowledge additional information		
7. Do you have a weakened immune system? (Cancer, Chemotherapy, High Does Steroids, etc.?)	☐	☐
8. Are you currently pregnant?	☐	☐
9. Are you currently breastfeeding?	☐	☐
If "YES" to any of questions 10-11, vaccinate with *30*-minute observation		
10. Do you have a history of a severe allergic reaction to any of the following?		
• Any non-COVID Vaccine?	☐	☐
• Any foods, peanuts, pets, insects, venom, environmental, latex?	☐	☐
• Any Injectable medication, including biologics?	☐	☐
11. Have you been advised to carry an EpiPen?	☐	☐

For administrative use only

Vaccine	Type	Age	Dose/Route/Site
COVID-19 mRNA Vaccine ( )	**MDV**		**0.5 ml** ☐ **IM** ☐ **L** ☐ **/ R** ☐ **Deltoid** ☐
Lot:	**Expiration:**		

Administered by: _____

print name *signature*

Date Administered: _____