Salem County Department of Health & Human Services

COVID-19 Vaccine Consent Form-ADULT PERSONS OVER 18

For more information, call: 856-935-7510, Ext. 8476 or 8482

The Salem County Department of Health will keep this medical record on file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

I have read or have had explained to me the vaccine fact sheet provided to me about the COVID-19 vaccine I am to receive. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the COVID-19 vaccine and ask that the vaccine be given to me. **Please initial: _________**

For 1st Dose Appointments ONLY:

I have been provided the projected date that the Salem County Department of Health will administer my second dose of the COVID-19 vaccine. I understand that if I cancel this provided appointment for any reason, I assume full responsibility to schedule a second dose appointment at another available location, and that the Salem County Department of Health cannot guarantee me an appointment to receive the second dose of my COVID-19 vaccine on a different date. **Please initial: _________**

Please circle your answers to the following questions: Are you or the person receiving the vaccine:

18 years old or above? **Yes** **or** **No**
Allergic to latex? **Yes** or **No**

Privacy Policy

– I have seen and been informed of the Privacy Practices of the Salem County Health & Human Services Department, and I authorize the use and disclosure of my Medical Information concerning the COVID-19 vaccine as per these practices. I have seen or been offered the vaccine fact sheet for the vaccine I am receiving today.

-- I give my permission for my immunization information to be included in the ***NJ Immunization Information System.*** Information about this program is available upon request.

Authorization of Treatment; Acknowledgement and Assumption of Risk; Waiver of Liability, Indemnification, and Medical Release --On my behalf and/or behalf of any person to whom I have power of attorney over, I am aware of the personal health dangers and the risk of physical injury. I also understand there may be additional or different risks of which I am not aware. I understand that the Department does not insure participants for loss or warrant successful treatment shall occur. I voluntarily elect to participate in this immunization activity with knowledge that I may be harmed and I agree to accept and assume all risk of personal injury or death. In consideration for treatment occurring on my behalf or on behalf of any person to whom I have power of attorney over I waive, release and discharge the Department, its officers, agents, volunteers and employees inclusive, for all reckless or negligent behavior causing death, disability, personal injury, property damage, loss or other claims which may accrue to me or my estate as the direct or indirect result of participation in the immunization treatment. I shall further defend, indemnify and hold harmless the Department, its officer, agents, volunteers and employees inclusive, against any and all claims of any nature, inclusive of costs, expenses and reasonable attorney's fees, which is any way or manner result from participation in the referenced treatment. I further consent to receive or permit any person to whom I have power of attorney over that has received the COVID-19 vaccine, to receive all necessary medical treatment deemed advisable and offered by the Department's staff.

Read Before Signing

I have read this form and I acknowledge that I believe I fully understand its terms and provisions, including the fact that I am giving up certain legal rights in consideration of receiving treatment.

____ M F

Last Name First MI Birth date Age Sex

____

Address City State ZIP County

X _____________________________ Telephone # ______________

Signature/Person to receive vaccine

Clinic/Office Address: Salem County Health Department

Site of injection: ___ Left Deltoid ___Right Deltoid ____Other

Signature/Title of Vaccine Administrator

____

Reviewed By:

Label
Date/Place Vaccine administered
Exp. Date and Lot #

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name ______________________

Age __________

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today.
If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked.
If a question is not clear, please ask your healthcare provider to explain it.

Question	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product ______			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of a COVID-19 vaccine including either of the following:			
○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
• A previous dose of COVID-19 vaccine.			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			

Form reviewed by ______________________ **Date** ______________