RIVERSIDE HEALTH SYSTEM 2022
Community Vaccine Clinic
COVID-19 Vaccination Consent Form

Part A: Patient to complete and sign at "X" below

Full Legal Name _____

Date of Birth _____ **Gender** _____

Address _____

_____

Phone Number _____

Email _____

IF PATIENT IS UNDER 18:

Legal Guardian Name _____

Date of Birth _____ **Gender** _____

Address (if different than above) _____

_____

Phone Number _____

Please check appropriate box:

	Yes	No
1. Have you had a severe (life-threatening) allergic reaction to any vaccine or injectable medication?		
2. Do you have a fever or other symptoms of acute illness?		
3. Have you received COVID-19 monoclonal antibody or convalescent plasma in the last 90 days?		
4. Are you allergic to latex?		

I have been provided and read the COVID-19 vaccine Fact Sheet for Receipients and Caregivers.
I have had a chance to ask questions which were answered to my satisfaction.

I understand the benefits and risks of COVID-19 vaccine and request that the COVID-19 vaccine be given to me or to the person for whom I am authorized to make this request.

X _____ **Date** _____

Signature of person receiving COVID-19 vaccine or person authorized to make the request if person receiving COVID-19 vaccine is a minor

Part B : To be completed by RHS Covid-19 Vaccination Team

Given:

- ☐ Pfizer INFANT COVID-19 Vaccine 0.1mg/0.2 ml IM
- ☐ Pfizer PEDIATRIC COVID-19 Vaccine 0.1mg/0.2 ml IM
- ☐ Pfizer ADULT COVID-19 Vaccine 0.3mg/0.3 ml IM
- ☐ BIVALENT COVID-19 Vaccine 0.3mg/0.3 ml IM

Site/Deltoid: ☐ Right ☐ Left

Administered By (Name & Credentials): _____