

**LIBERTY DAYTON REGIONAL MEDICAL CENTER  
COVID-19 IMMUNIZATION CONSENT FORM**

I have been provided and have read, or had explained to me, the information sheet regarding the COVID-19 vaccination. I understand that this vaccine requires two doses; both doses of this vaccine will need to be administered in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccination as described. I request that the COVID-19 vaccination be given to me. I authorize release of all information as needed for public health purposes, including reporting to applicable vaccine registries.

Employee YES \_\_\_\_\_ NO \_\_\_\_\_ Department: \_\_\_\_\_

\_\_\_\_\_  
Last name First name DOB

**Screening**

1. Are you feeling sick today?  Yes  No
2. In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?  Yes  No  Unknown
3. Have you been treated with antibody therapy for COVID-19 in the past 90 days (3 months)? If yes, when did you receive the last dose?  Yes  No  Unknown
4. Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot?  
 Yes  No  Unknown
5. Have you had any vaccines in the past 14 days (2 weeks) including flu shot+? If yes, how long ago was your most recent vaccine?  Yes  No  Unknown
6. Are you **pregnant** or considering becoming pregnant?  Yes  No  Unknown
7. Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?  Yes  No  Unknown
8. Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?  Yes  No  Unknown

Which vaccine is the patient receiving today?			
Vaccine Name	Administration		EUA Fact Sheet Date
Pfizer/ BioNTech	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	
Moderna	<input type="checkbox"/> First Dose	<input type="checkbox"/> Second Dose	

**Administration Site**  Left Deltoid  Right Deltoid  other/specify \_\_\_\_\_

**Dosage:**  0.5 ml  0.3ml

- I have reviewed side effects with patient
- I confirm that the patient was given an opportunity to ask questions about the vaccination, and all the questions asked by them have been answered correctly and to the best of my ability.

\_\_\_\_\_  
Vaccinator Signature

\_\_\_\_\_  
Date

**Emergency Use Authorization**

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.