COVID-19 Immunization Consent Form

VERMONT DEPARTMENT OF HEALTH

SECTION 1: PATIENT INFORMATION

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

PARENT/LEGAL GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE NAME (If the patient is under 18, or has a legally authorized representative to make medical decisions): _____

DAYTIME PHONE NUMBER: _____

SECTION 2: COVID-19 VACCINE

Please select the reason you or the patient with you is receiving COVID-19 vaccine today:

❑ **Have not been vaccinated or completed a COVID-19 vaccine series.**

❑ **Have completed a COVID-19 vaccine series but meet a high-risk health or other condition which makes me eligible for an additional dose.**

- Been receiving active cancer treatment for tumors or cancers of the blood
- Received an organ transplant and are taking medicine to suppress the immune system
- Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
- Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- Advanced or untreated HIV infection
- Active treatment with high-dose corticosteroids (≥20mg prednisone or equivalent per day) or other drugs that may suppress one's immune response
- Received a vaccine licensed in another country (such as the AstraZeneca vaccine, the Sputnik V vaccine, or the Sinovac) as part of working and living abroad.
- Received a COVID-19 vaccine not yet licensed in the US (such as the AstraZeneca vaccine) as a volunteer in a formal clinical trial of vaccine efficacy.

❑ **Am eligible for a booster dose**

- 18 or older and received
    - Johnson & Johnson vaccine at least two months ago, or
    - Second dose of Moderna vaccine at least five months ago
- 12 or older and received a second dose of Pfizer vaccine at least five months ago

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SECTION 3: SIGNATURE

By signing below, I declare that

- I am the patient and at least 18 years of age, or the parent, legal guardian of the patient, or legally authorized representative of the patient.
- If I am the legal guardian or legally authorized representative, I certify I have the legal authority to consent on behalf of the patient.
- I have been given a copy of the Emergency Use Authorization (EUA) for Vaccine Recipients or the Vaccine Information Statement for the COVID-19 vaccine I will receive today.
- I have read and understand the information contained in the EUA for Vaccine recipients or the Vaccine Information Statement.
- I have been given the opportunity to ask questions about the COVID 19 vaccine.
- I understand the benefits and risks of the COVID-19 vaccine and ask that the vaccine be given to the person named above for whom I am authorized to provide consent.

PATIENT'S SIGNATURE: _____

PARENT/LEGAL GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE NAME (If the patient is under 18, or has a legally authorized representative to make medical decisions): _____

DATE CONSENT FORM SIGNED: _____