Public Health
Prevent. Promote. Protect.
Rock Island County Health Department

SchoolHealthLink

COVID-19 Vaccine Consent Form

Name (Last, First, MI)	**DOB:** / /
Address	**Age:**
City/State/ZIP	
Phone	

Your primary care doctor/provider's name, city, state: _____

Insurance name and ID number: _____

Required by the State of Illinois:

Race: Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown ☐

Ethnicity: American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ Other Race ☐ Unknown ☐ White ☐

	YES	NO
Have you ever had a serious reaction to a vaccine or other injectable drug, if yes, which medication and what was the reaction? Allergy to Polysorbate or PEG, if yes, what was the reaction?	☐	☐
Do you have any other serious allergies? Please list:	☐	☐
Have you received a previous single dose or 2-dose series of a COVID-19 vaccine? If yes, number of doses and brand of vaccine:	☐	☐
Are you able and willing to remain onsite for 15-30 minutes after your vaccine?	☐	☐
Have you received or plan on receiving any vaccinations within the past or next two weeks?	☐	☐

☐ **I have read or had explained to me the COVID-19 Vaccine EUA Fact sheet and understand the risks and benefits. I GIVE CONSENT to the Rock Island County Health Department authorized employee or designee to administer the COVID-19 Vaccination.**

Signature: _____ Date: _____

Vaccine recipient (or Parent/Guardian, if applicable)

Vaccination Record (FOR ADMINISTRATIVE USE ONLY)

EUA provided: Y / N Vaccination Card provided: Y / N If vaccine deferred, please state reason:

Temperature:

Vaccine: COVID-19	Route: IM Deltoid	Date Administered	Manufacturer	Lot Number	Name & Title of person administering vaccine
Dose #1	L R		Pfizer Moderna		
Dose #2	L R		Pfizer Moderna		