**COVID-19 Vaccine Consent**

**Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please Check One of the Following:**

\_\_\_\_\_ MSU Employee- Employee #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dept: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ MSU Student- Student #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes No**

|  |  |  |
| --- | --- | --- |
| Answer Yes or No: |  |  |
| 1. Do you have a history of severe allergic reaction to anything? (i.e., Anaphylaxis/airway involvement?) |  |  |
| Day of Vaccination, Answer Yes or No? |  |  |
| 1. Do you currently have moderate or severe illness (with or without fever)? |  |  |
| 1. Are you sick today? |  |  |
| 1. Have you received ANY vaccination within the last 14 days? |  |  |

\*I am aware that the COVID-19 vaccine has been approved via the Emergency Use Authorization process by the FDA.

\*I am aware of the Fact Sheet for Recipients and Caregivers from the Emergency Use Authorization.

\*I am aware that the Johnson & Johnson Janssen COVID-19 vaccine is administered in 1 dose.

\*I am aware of the risks and benefits of the vaccine as described and request that the vaccine be given to me.

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To Be Completed by Administering Nurse:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Right or Left Deltoid  
 Manufacturer Lot Number Expiration Date Site Administered (circle one)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Administering Nurse Name (Print) Administering Nurse Signature Date Administered