INFORMED CONSENT: COVID-19 VACCINATION 2021

LSU Health NEW ORLEANS

Last Name: (print)	**First Name:**	**Middle I:**
Address:		
City:	**State:**	**Zip:**

Phone: (area code)	**Cell Phone: (are code)**

DOB:	**Age:**	**Email Address:**

Race:		**Ethnicity:**
___American Indian or Alaska Native	___Asian	___Hispanic or Latino
___Black or African American	___White or Caucasian	___Not Hispanic or Latino
___Native Hawaiian or Other Pacific Islander	___Other	___Decline

	YES	**NO**
Have you received a dose of the Covid-19 vaccine before? If you did not receive the Pfizer vaccine, please indicate which one:		
CHECK **ANY THAT APPLY** AND **NOTIFY THE NURSE PRIOR TO ADMINISTRATION**	**YES**	**NO**
Are you experiencing any COVID-like symptoms including but not limited to fever (>100.0), shortness of breath, dry cough, runny nose, sore throat, muscle pain, or loss of taste or smell?		
Have you been diagnosed with any of the following conditions? • HIV infection • Immunosuppression (weakened immune system) • Autoimmune conditions		
Have you received monoclonal antibodies or convalescent plasma for treatment of COVID-19 infection in the past 90 days?		
Do you have a significant history of allergic reactions to vaccines, medicine, or food, such as an anaphylactoid reaction, or have you been advised to carry an adrenaline autoinjector with you (EpiPen)?		
For women: Are you pregnant or breastfeeding or is there a chance you could become pregnant during the next month?		
If you answered yes to any of the questions above, you may want to speak with your physician before receiving the vaccine.		

I have received *VACCINE INFORMATION FACT SHEET FOR RECIPIENTS AND CAREGIVERS ABOUT COMIRNATY (COVID-19 VACCINE, mRNA) AND PFIZER-BIONTECH COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19)* about the COVID-19 vaccine and have had chance to ask questions and had them answered to my satisfaction.

- I understand that the common side effects for adults include soreness and redness at the injection site, fever, muscle aches, headaches, and tiredness.
- I have read the information provided on this form, and I have answered all questions honestly.
- I give my permission to release this COVID-19 documentation to other medical care providers to avoid unnecessary vaccinations and to determine immunization status.
- I understand that I am to wait **15 – 30 minutes** after receiving the COVID-19 vaccine before leaving the building.

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- As recommended, I have discussed any situation (and others) listed above with my healthcare provider and agree to proceed with the COVID-19 vaccination.
- **I understand the benefits and risks of the COVID-19 vaccine and I hereby authorize and consent to receive the vaccination.**

I GIVE CONSENT to Louisiana State University Health Sciences Center New Orleans (LINKS Organization ID #1680) to vaccinate me for the COVID-19 virus.

I also agree to allow information about all vaccinations given to me or to the person from whom I am authorized to consent to be release to other medical care providers or schools to avoid the administration of unnecessary vaccinations and to determine immunization status. I understand this will remain in effect until canceled by me in writing.

SIGNATURE (vaccine recipient): _____ Date: _____

IF MINOR: NAME OF PARENT/AUTHORIZED TO CONSENT (please print): _____

SIGNATURE of Parent/other authorized to consent: _____

RELATIONSHIP TO RECIPIENT: _____ Date: _____

FOR OFFICE USE ONLY:

VACCINE NAME:	IMMUNIZATION LOT# & EXPIRATION DATE	DOSE GIVEN	INJECTION SITE/ROUTE	DATE	TIME	VACCINE ADMINISTRATOR SIGNATURE
COVID-19 Manufacturer: Pfizer	LOT FH8028 Exp 5/31/2022	.3mL	R / L IM			