# INFORMED CONSENT: COVID-19 VACCINATION 2022

LSU Health NEW ORLEANS

** Name, DOB and zip code must match your Louisiana Driver's license in order to cross over to the LA Wallet app

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

| **Phone: (area code)** | **Cell Phone: (area 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 any COVID-19 vaccinations within the last 2 months? | | |
| 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?<br>• Myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside the heart)?<br>• Bleeding disorder or are on a blood thinner?<br>• Immunocompromised or are on a medicine that affects your immune system?<br>• Pregnant, plan to become pregnant or breastfeeding? | | |
| Do you have a significant history of allergic reactions to vaccines, medicine, or food, such as an anaphylactic reaction, or have you been advised to carry an adrenaline auto injector with you (EpiPen)? | | |
| Have you ever fainted in association with an injection? | | |
| **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 the **VACCINE INFORMATION FACT SHEET FOR RECIPIENTS AND CAREGIVERS ABOUT COMIRNATY (COVID-19 VACCINE, mRNA), THE PFIZER-BIONTECH COVID-19 VACCINE, AND THE PFIZER-BIONTECH COVID-19 VACCINE, BIVALENT (ORIGINAL AND OMICRON BA.4/BA.5) TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) FOR USE IN INDIVIDUALS 12 YEARS OF AGE AND OLDER** 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.
- 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 | | .3mL | R / L | | | |
| Manufacturer: | | | | | | |
| Pfizer | | | IM | | | |