CASWELL COUNTY HEALTH DEPARTMENT
COVID-19 VACCINE CONSENT FORM

❶ **Is this your first dose?**	❷ **Is this your second dose?**
• Complete Section 1 • Complete Section 2 • Sign and Date Section 3	• Section 1 - We only need your name, date of birth, and email address. • Complete Section 2 • Sign and Date Section 3

Section 1 – PATIENT INFORMATION

Last Name		**First Name**		**Middle Initial**	
Date of Birth		**Email Address**			
Street Address		**City**		**State**		**Zip**	
County		**Home Phone**		**Cell Phone**	
Race *(Check one)*	❑ Black/African American ❑ White/Caucasian ❑ American Indian/Alaskan ❑ Native Asian/Pacific Islander ❑ Other				
Ethnicity *(Check one)*	❑Hispanic ❑Non-Hispanic	**Gender**	❑ Male ❑ Female		

Section 2 – SCREENING SECTION

Question	Answer
1. Are you allergic to any medications, foods, or products? If so, please list: ___________ ____________________	❑ Yes ❑ No
2. Have you ever had a serious allergic reaction? If so, what kind? ____________________	❑ Yes ❑ No
3. Do you carry an epi-pen?	❑ Yes ❑ No
4. Do you no have a fever with a temperature above 100 degrees/or are you sick today?	❑ Yes ❑ No
5. Are you currently experiencing any COVID-like symptoms or have you been in close contact with anyone diagnosed with COVID-19 in the last 14 days?	❑ Yes ❑ No
6. Have you been vaccinated with any vaccine (including flu) in the past 14 days?	❑ Yes ❑ No
7. Have you tested positive for COVID-19 in the last 90 days?	❑ Yes ❑ No
8. Have you been treated for COVID-19 infection with plasma (or passive antibody therapy) in the last 90 days?	❑ Yes ❑ No
9. Do you have a bleeding disorder or do you take a blood thinner?	❑ Yes ❑ No
10. Are you currently pregnant or breastfeeding?	❑ Yes ❑ No

Section 3 - CONSENT

I have read and understand information provided to me concerning the receiving of vaccines for COVID-19 and have had the opportunity to ask questions. I give my permission to receive COVID-19 vaccine. I authorize the provider of service to release information necessary for the processing of any claim for payment made on my behalf, and I authorize payment to the provider for such claim.

Signature		**Date**	

FOR HEALTH DEPARTMENT USE ONLY			
Vaccine Mfg/Lot #		**Clinic Location**	❑ CCHD ❑ Parks & Rec ❑ PCC ❑ Other: ______________
IM Admin. Site	❑ Right Deltoid ❑ Right Arm ❑ Left Deltoid ❑ Left Arm ❑ Right Thigh ❑ Left Thigh		
Vaccine Name	❑ Moderna ❑ Janssen	***Allergies & Reactions***	
CPT Code: 91301	❑ 0011A (1st dose) ❑ 0012A (2nd dose)		

________________________________ ________________ ________

Vaccinator Signature Date Time