COVID-19 Janssen Vaccination

PLEASE PRINT

Patient *FIRST* Name: **_LAST_ Name:** **MI:**

Maiden Name (Optional):

DOB: / / **Current Age:** **Sex:** ☐ F ☐ M ☐ Other

Race: ☐White ☐Black or African American ☐Asian ☐American Indian or Alaskan Native ☐Other ☐Native Hawaiian or Other Pacific Islander ☐Unknown

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Unknown

Address: **City:** **State:** **Zip:**

Cell Phone: ( ) **Alternate Phone:** ( )

The following questions will help determine if there is any reason you should not receive a COVID immunization injection. Questions should be answered for the person who will be vaccinated.
If a question is not clear, please ask a healthcare provider to explain.

1.	Younger than 18 years old?	☐ Yes	☐ No
2.	History of any immediate (severe) allergic reaction to any components of the Janssen COVID-19 vaccine?	☐ Yes	☐ No
	Cause/Allergy: _____		
3.	History of immediate allergic reaction of any severity to any substance?	☐ Yes	☐ No
	Cause/Allergy: _____		
4.	Ever received a COVID-19 vaccine?	☐ Yes	☐ No
	Date: _____ **Manufacturer:** _____		
5.	Sick today, including symptomatic/asymptomatic infection with COVID-19?	☐ Yes	☐ No
6.	Received passive antibody therapy for COVID-19 in the last 90 days?	☐ Yes	☐ No
7.	Received any vaccine in the past 14 days?	☐ Yes	☐ No
8.	Pregnant or breastfeeding?	☐ Yes	☐ No

Request for Administration of COVID-19 Vaccine for the above-named recipient: I acknowledge that I have received the Vaccine Information Statement or Emergency Use Authorization Information Sheet and a Notice of Privacy Practices. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits.

PATIENT/PARENT OR GUARDIAN/POWER OF ATTORNEY SIGNATURE: _____ **DATE:**_____

This consent is valid for 12 months from date signed.