SAN BERNARDINO COUNTY | Public Health

COVID-19 Vaccination Adult Consent Form

Patient Information (please print):		
Last Name	*First Name*	*Middle Name*
Date of Birth (MM/DD/YYYY)	*Age*	*Phone Number*
Street Address, City, State, Zip Code		
Email	*Mother's Maiden Name (Maiden Last Name, First Name)*	

Gender: (Check one)	*Race: (Check one)*			*Ethnicity (Check one):*
☐ Female	☐ American Indian	☐ White	☐ Other Pacific Islander	☐ Hispanic
☐ Male	☐ Alaska Native	☐ Black or African American	☐ Decline to Answer	☐ Non-Hispanic
☐ Decline to Answer	☐ Asian	☐ Native Hawaiian	☐ Other _____	

Patient Eligibility Status Verification: these questions are to assess your health insurance status and extent of your coverage to help determine if you meet eligibility criteria for COVID-19 vaccines through our various programs.

The patient named above qualifies for COVID-19 immunizations through the **Bridge Access Program (BAP/317)** because he/she is 19 years of age and older and: **(Choose only one of the following.)**

☐ Is uninsured (does not have private health insurance); or

☐ Is underinsured, meaning insurance coverage does not cover COVID-19 vaccines.

The patient named above qualifies for COVID-19 immunizations through the **San Bernardino County Department of Public Health Vaccination Program** because he/she:

☐ Has health insurance that pays for vaccines.

Screening Questions

	YES	NO	UNKNOWN
1. Are you feeling sick today? (i.e., fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headaches, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea)	☐	☐	☐
2. Have you had an allergic reaction to a component of a COVID-19 vaccine, including: • Polyethylene glycol (PEG), which is found in some medications such as laxatives and preparations for colonoscopy procedures	☐	☐	☐
• Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids	☐	☐	☐
• A previous dose of COVID-19 vaccine	☐	☐	☐

3. Check all that apply to the patient receiving the vaccine:
   - ☐ Male between ages 12 and 39 years old
   - ☐ Has a history of myocarditis or pericarditis
   - ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
   - ☐ Has a bleeding disorder
   - ☐ Takes a blood thinner
   - ☐ Vaccinated with monkeypox (MPOX) in the last 4 weeks
   - ☐ Has a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies
   - ☐ Has received dermal fillers
   - ☐ Have received the COVID-19 vaccine before or during hematopoietic cell transplant (HCT) or CAR-T-cell therapies

Note: Please continue to page 2.

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Patient Eligibility: _____

Initials: _____

Consent
I have been given a copy and have read the Emergency Use Authorization (EUA) and reviewed the FDA Fact Sheet for Recipients and Caregivers for the COVID-19 vaccine product. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) be given to the person named above for whom I am authorized to make the request. I understand that all vaccines have risks and side effects; and that there may be risks that are not known yet. I attest that, to the best of my knowledge and belief, all information reported in this document is accurate and complete. As required by state law (Health and Safety Code, § 120440), all immunizations will be reported to the California Immunization Registry (CAIR2). I understand the information in my CAIR2 record will be shared with the local health department and State Department of Public Health, shall be treated as confidential medical information, and shall be used only to share with each other or as allowed by law. I may refuse to allow the information to be further shared and can request the CAIR2 record be locked by visiting https://bit.ly/LockMyCAIRRecord. By signing this form, I give San Bernardino County and participating vaccination partners permission to contact me regarding COVID-19 vaccine reminders and access to electronic vaccination records.
☐ **By checking the box, I give consent to be vaccinated with the COVID-19 vaccine and understand that I am receiving the vaccine voluntarily.** I release County of San Bernardino, its employees, and representatives from any liability or further responsibility with regard to receiving the vaccine.

Signature	*Date*

I certify that I am the patient's legal representative and/or legal conservator and I am authorized by the patient or other legal authorities to sign and accept the listed terms on behalf of the patient.	
Signature of Legal Guardian (Medical Power of Attorney)	*Date*
Legal Guardian Printed Name	

FOR OFFICE USE ONLY – SARS CoV-2 VACCINATION RECORD	
Vaccine Formulation: ☐ Spikevax 12+ years	**Date Administered:** _____ /_____ / _____
Manufacturer: ☐ Moderna	**Dose:** _____mL **Route:** Intramuscular (IM)
Lot #:	**Site:** ☐ Left Deltoid ☐ Right Deltoid ☐ Left Anterolateral Thigh ☐ Right Anterolateral Thigh
Expiration Date:	**Vaccine Administered By**
EUA Fact Sheet or VIS Given: ☐ Yes ☐ No	**Name (please print):** **Signature:**
VIS Date:	**Title:** ☐ RN ☐ LVN ☐ Pharmacist ☐ _____
Vaccine Source: ☐ BAP/317 ☐ PRIVATE ☐ VFC	

Digital Vaccine Record Portal

Immunization Registry Notice to Patients and Parents

Spikevax 12+ years VIS for Recipients and Caregivers