JOHNSON COUNTY KANSAS
Health & Environment

COVID-19 Vaccine Consent Form

Last Name: _____ First: _____ MI: _____ DOB: _____

Address: _____ Apt #: ____ City: _____ State: ___ Zip : _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email: _____

Gender: ☐ Male ☐ Female Ethnicity: Hispanic or Latino ☐ Yes ☐ No

Race: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Unknown/Unreported

		(circle)	
1.	Are you under 18 years of age?	Y	N
2.	Are you experiencing moderate to severe illness and/or a fever?	Y	N
3.	Have you already received a dose of the COVID Vaccine?	Y	N
	3a. ___Pfizer ___Moderna ___Johnson & Johnson Date Received: _____		
4.	Have you had a severe allergic reaction (e.g., anaphylaxis) to any component of either Pfizer-BioNTech, Moderna or the Johnson & Johnson COVID-19 vaccines?	Y	N
5.	Have you received passive antibody therapy (monoclonal antibodies or convalescent plasma) as part of COVID-19 treatment within the past 90 days?	Y	N
6.	Are you pregnant?	Y	N
7.	Are you breastfeeding?	Y	N

By signing below:

- My signature authorizes JCDHE to share my immunization history with the state of Kansas Immunization Registry.
- I acknowledge that I have been offered a copy of the Department's Notice of Information Practices effective 05/06/19 and the Emergency Use Authorization Fact Sheet. I have read, had explained to me and had a chance to ask questions regarding the information. I consent for the vaccine to be given to me or the person named above for whom I am authorized to sign.

_____ ____/____/____ _____
Signature of Patient/Patient Representative Date Relationship to Patient

Children age 15 and younger must be accompanied by an adult. A parent/guardian is preferable; however, the parent/guardian may designate a non-parent adult to be present at the time of vaccination if the parent/guardian is unavailable.

_____ _____
Name of individual present at time of vaccination Relationship to child

_____
Signature of individual present at time of vaccination

Internal Use Only

Manufacturer: _____

Lot Number: _____ ☐ Left Delt ☐ Right Delt

Expiration Date: _____

_____ _____ ____/____/____
Signature of Vaccine Administrator Provider # Date