LAFENE+ HEALTH CENTER
YOUR STUDENT HEALTH RESOURCE

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myLAFENE+

VACCINE CONSENT FORM FOR COVID-19 VACCINES

Last Name *(Please print)*	First Name	MI	WID#

Phone Number	Date of Birth	Age

1. Are you feeling sick today?	Yes	No
2. Have you ever received a dose of COVID-19 vaccine?	Yes	No

If yes, which vaccine product did you receive?
☐ Pfizer ☐ Moderna ☐ Johnson & Johnson (Janssen)

3. Have you ever had an allergic reaction to:
(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)

• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications such as laxatives and preparations for colonoscopy procedures	Yes	No
• Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.	Yes	No
• A previous dose of COVID-19 vaccine	Yes	No
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine components, but it is not known which component elicited the immediate reaction.	Yes	No
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	Yes	No
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.	Yes	No
6. Have you received any vaccine in the last 14 days?	Yes	No
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	Yes	No
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	Yes	No
9. Do you have a weakened immune system caused by something such as HIV infection or cancer, or do you take immunosuppressive drugs or therapies?	Yes	No
10. Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No
11. Are you pregnant or breastfeeding?	Yes	No
12. Do you have dermal fillers?	Yes	No

CONSENT FOR VACCINATION

I have been offered a copy of the Vaccine Information Statement (VIS) and/or Emergency Use Authorization (EUA) Fact Sheet for the vaccine. I understand and am aware I am advised to wait for a minimum of 15 minutes post vaccination for monitoring. I have read the information and my questions have been answered satisfactorily. I consent to the inclusion of this immunization data in the Kansas Immunization Registry.

Signature of Patient _____ Date _____

FOR ADMINISTRATIVE USE ONLY

Vaccine	Route	Manufacturer	Lot No.	Signature of Vaccine Administrator
COVID-19	IM *RT* *LT*	☐ Moderna ☐ Pfizer ☐ Johnson & Johnson		