LAFENE+ HEALTH CENTER
YOUR HEALTH & WELL-BEING 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? ☐ Johnson & Johnson (Janssen) ☐ Moderna ☐ Novavax ☐ Pfizer ☐ Another Product _____		
Have you received a complete COVID-19 series? (i.e. 1 dose Janssen or 2 doses [Moderna, Pfizer-BioNTech, Novavax]) Date of last COVID-19 vaccine (primary series or booster):_____	Yes	No
3. Do you have a health condition or are you undergoing treatment that makes you moderately or severely immunocompromised? *(This would include treatment for cancer or HIV, receipt of organ transplant, immunosuppressive therapy or high-dose corticosteroids, CAR-T-cell therapy, hematopoietic cell transplant [HCT], or moderate or severe primary immunodeficiency.)*	Yes	No
4. Have you received a COVID-19 vaccine before or during hematopoietic cell transplant (HCT or CAR-T-cell therapies)?	Yes	No
5. 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 caused hives, swelling, or respiratory distress, including wheezing.)*		
A component of the COVID-19 vaccine	Yes	No
A previous dose of COVID-19 vaccine	Yes	No
6. 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 caused hives, swelling, or respiratory distress, including wheezing.)*	Yes	No
7. Do you have history of myocarditis or pericarditis?	Yes	No
8. Have you ever been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A)?	Yes	No
9. Do you have a history of an immune-mediated syndrome defined by thrombosis and thrombocytopenia such as herapin-induced thrombocytopenia (HIT)?	Yes	No
10. Do you have history of thrombosis and thrombocytopenia syndrome (TTS)?	Yes	No
11. Do you have history of Guillain Barre syndrome (GBS)?	Yes	No
12. Do you have a history of COVID-19 disease in the past 3 months?	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**	**Lot No. / Manufacturer**	**Signature of Vaccine Administrator**
COVID-19 ☐ Moderna Monovalent ☐ Moderna Bivalent	**IM** ***RT*** ***LT***		