2020-2021 Sars-Cov-2 COVID-19 Vaccine Consent Form
Hillsdale Hospital
Hillsdale, Michigan

Information about Individual to Receive Vaccine (Please Print)

NAME (Last)	(First)	(M.I.)

D.L. #	DATE OF BIRTH: Month: Day: Year:

ADDRESS			
CITY	**STATE**	**ZIP**	**DAYTIME PHONE NUMBER**

Screening for Vaccine Eligibility

The answers to the following questions will help is to determine if you can get the COVID vaccine. Please mark YES or NO for each question.	YES	NO
1. Are you ill today?	☐	☐
2. Have you tested positive for COVID-19 in the past 14 Days?	☐	☐
3. Have you ever had a serious/life threatening reaction to any vaccine in the past	☐	☐
4. Have you received any vaccinations in the last 4 weeks?	☐	☐
5. Have you ever had Guillain-Barre Syndrome? (Guillain-Barre Syndrome is a type of temporary severe muscle weakness)	☐	☐
6. Are you Pregnant?	☐	☐
7. Do you have cancer, leukemia, HIV/AIDS or other immune system problems?	☐	☐
8. During the past year have you received blood or blood products or been given immune globin or antiviral drugs?	☐	☐
9. Do you have a weakened immune system or in the past 3 months taken any medication that weaken it such as cortisone, prednisone or other steroids or radiation treatments?	☐	☐
10. Are you on any anticoagulation medications? (blood thinners)	☐	☐
11. Do you have a long term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, diabetes, anemia or blood disorders?	☐	☐

DEPARTMENT OR AGENCY EMPLOYED IN_____

CONSENT FOR VACCINATION:

By signing I am giving consent for the COVID vaccination. I have been provided with information regarding the vaccine I am receiving. I understand that this is a 2-dose vaccination and I will be required to receive my 2nd dose at the time frame given by the manufacturer. I understand that if I should have a reaction that I feel is severe, I can report this to the VAERS.com website. I Further understand that this is provided based on the Emergency Use Authorization given by the FDA and do not hold Hillsdale Hospital or any of person providing this vaccination responsible for any reactions that I may potential have.

Signature of person receiving vaccine:

Sign:_____

Date:_____

Date Administered	Route	Dose	Injection Site	Vaccine Manufacturer	Lot Number
	IM		R or L deltoid	PFIZER	
Signature of Vaccine Administrator					

Date Administered	Route	Dose	Injection Site	Vaccine Manufacturer	Lot Number
	IM		R or L deltoid	PFIZER	
Signature of Vaccine Administrator					