LAWNDALE CHRISTIAN HEALTH CENTER
Loving God. Loving People.

Adult COVID-19 Immunization Consent Form

PLACE LABEL HERE

Consent

I would like to receive the COVID-19 vaccine. I understand that the vaccine has been authorized by the Food and Drug Administration for emergency use only.

I certify that I have received and understand the information contained in the Emergency Use Authorization Fact Sheet for Recipients and Caregivers, which contains important information about the COVID-19 vaccine's known risks, side effects, and benefits. I am aware that I may have other adverse reactions or side effects and that there are risks that remain unknown, as the vaccine is still in clinical trials.

I certify that I meet the current requirements to receive the COVID-19 vaccine:

__ I am not currently ill with fever, cough, shortness of breath, nasal congestion, diarrhea or vomiting or loss of taste or smell

__ I have not tested positive for COVID 19 in the past 21 days.

__ I have not received another vaccine in the past 14 days.

__ I have not received antibody therapy for COVID-19 in the past 90 days.

__ I have not had a severe allergic reaction to a previous dose of any vaccine or any medication that is injectable; for example, a reaction which required the use of epinephrine.

__ I do not have a history of an immediate allergic reaction such as hives, swelling or difficulty breathing within 4 hours of receiving an mRNA vaccine such as the Moderna COVID-19 vaccine.

__ I have no known allergy to polysorbate or polyethylene glycol (PEG, an ingredient that is often found in some laxatives and bowel prep)

__ I do not have a history of severe allergic reactions, such as those requiring use of epinephrine, to foods, pet, venom, environment or latex

__ If I have had an allergic reaction such as this, I agree to stay to be observed for 30 minutes.

I understand that two doses of the COVID-19 vaccine are necessary for the vaccine to be fully effective.

I have had the opportunity to ask questions regarding the vaccine and these have been answered to my satisfaction. If pregnant, breastfeeding, or immunocompromised, I have had the opportunity to discuss with my primary care provider and desire to be vaccinated.

I understand that this vaccine is voluntary. I consent to my COVID-19 vaccination record being stored and maintained in Lawndale Christian Health Center's electronic medical record system, which may be viewed or inspected by my health care providers and, if employed by LCHC, by LCHC's Employee Health team.

I agree to stay in the clinical area where I receive the vaccine for at least 15 minutes after the injection as directed.

Name: _____ Date: _____

Signature: _____