COVID-19 Vaccine Acknowledgement Form

Patient's Name (the person getting the vaccine): _____ **D.O.B** _____

	YES	NO
1. **Has the patient received a COVID vaccine in the past 7 months? If so when and which brand?** _____		
2. **Has the patient ever had a severe allergic reaction (anaphylaxis) to anything?** **Has the patient ever been prescribed an Epipen?**		
3. **Has the patient ever had a severe allergic reaction (anaphylaxis) after receiving a COVID19 vaccine, another vaccine, or injectable medication?**		
4. **Has patient had a severe allergic reaction to a component of the COVID-19 vaccine, including polysorbate or polyethylene glycol (PEG), which is found in some medications, such as laxatives like Miralax and preparations for colonoscopy procedures?**		
5. **Has the patient received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19 in the past 90 days?**		
6. **Does the patient have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?**		
7. **Does the patient have a bleeding disorder or are you taking a blood thinner?**		
8. **Is the patient in quarantine or isolation for COVID-19?**		

Acknowledgement

I (the patient or parent/guardian if patient is under 18 years of age) have been provided the opportunity to read information and ask questions. **I understand that vaccination is a voluntary decision made after discussion with my (or my child's) clinician, and that insurance coverage may vary; I may be responsible for payment if my insurer denies coverage.** I (the patient or parent/guardian if patient is under 18 years of age) hereby give my consent to the staff of The Maryland Pediatric Group to administer the COVID-19 vaccine.

Signature of Patient (or parent/guardian if patient < 18 yrs): _____

Name of Signer: _____

If patient under 18 years of age, relationship to the patient: _____

Date: _____

Staff initials: _____