VENTURA COUNTY PUBLIC HEALTH
A Department of Ventura County Health Care Agency

**COVID-19 Vaccine Administration Record and Informed Consent**

**Section A Personal Information**

First Name: _____ Last Name: _____ Date of birth: _____

Age: _____ Gender: ☐ Female ☐ Male ☐ Non-binary Phone: _____

Home address: _____

State: _____ Zip code: _____ Email: _____

(Check as many as applicable) The recipient of the COVID-19 vaccine is:

☐ Adult (age 18+) ☐ minor with a custodial parent or legal guardian

☐ minor who is (circle one):

emancipated by court pregnant married minor-parent without a parent/legal guardian

I have received and read the Emergency Use Authorization Fact Sheets for Recipients and Caregivers ☐ Yes ☐ No

| Section B | COVID-19 Vaccination Eligibility* | | |
|---|---|---|---|
| 1. | Are you currently under quarantine orders as a result of known COVID-19 exposure, or pending results of symptomatic testing? | Yes | No |
| 2. | Are you experiencing any COVID/ILI-like symptoms such as fever, chills, fatigue, runny nose, cough, severe headache, sore throat, body aches, shortness of breath, or new loss of taste/smell? | Yes | No |
| 3. | Have you ever had a severe allergic reaction (e.g. anaphylaxis) to any component of a COVID-19 vaccine (for Pfizer vaccine: mRNA, injectable lipids, potassium chloride, potassium phosphate, sodium chloride, sodium phosphate, or sucrose) (For Moderna vaccine: mRNA, Lipids(fats), Sodium acetate, Sucrose, Tromethamine, Tromethamine hydrochloride, Acetic acid) | Yes | No |
| 4. | Have you ever had a severe allergic reaction (e.g., anaphylaxis) to a COVID-19 vaccine? | Yes | No |
| 5. | Are you under the age of 18 years? For recipients 6 months to 17 years old, see below** | Yes | No |

*If you answered "Yes" any questions 1 to 4 above, the COVID-19 Vaccine is not recommended and should not be received. Consult with your primary care provider.

**If you are 6 months to 17 years old, your custodial parent or a legal guardian may consent on your behalf and sign this form; minors may not consent for vaccination unless they are emancipated by a court, pregnant, married, minor-parents, or a "minor seeking primary care" with verification of status in writing by a qualified adult under the IL Consent by Minors Act.

For ALL others, including minors: Along with my consent below, I will release and hold Ventura County Public Health harmless from any and all claims, demands (whether valid or invalid), damages, losses, actions, proceedings, fines, liabilities and expenses, including, but not limited to, any attorneys' fees, arising out of or alleged to have arisen out of,

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in whole or in part: (1) the administration of the COVID-19 vaccine, and (2) any adverse reaction or side effects as a result of receiving the COVID-19 vaccine.

**Section D COVID-19 Vaccination Consent**

I hereby give my consent freely to receive the COVID-19 vaccine, which is authorized by the Food and Drug Administration for emergency use only. I certify that I have reviewed and fully 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 and benefits, the risks that remain unknown to the Food and Drug Administration, and alternative COVID-19 vaccines available. I further certify that I/the recipient meet(s) the current requirements to receive the COVID- 19 vaccine. I understand and agree that it is my sole responsibility to discuss with my primary care provider any concerns I may have about the COVID-19 vaccination. After carefully considering all the information I have received, I voluntarily assume full responsibility for any adverse reactions or side effects, known or unknown, that may occur as a result of receiving the COVID-19 vaccine.

**Section E Signature for COVID-19 Vaccination Consent and Release of Liability**

Signature of Recipient/Parent/Legal Guardian: _____

Date: _____ Print Name: _____

Relationship of Consenting Party to Minor, if applicable: _____

Certified Interpreter, if utilized: _____ ID#: _____

**FOR HEALTHCARE PROVIDER ONLY**

(Complete **BEFORE** vaccination administration)

Vaccine Lot#: _____ Exp. Date: _____

Diluent Lot#: _____ Exp. Date: _____

I have reviewed Sections A and B above, the vaccination NDC, Lot and Expiration date. Initial: _____

Complete AFTER vaccine administration:

| Vaccine | NDC | Mfq | Dosage | Admin. Site | EUA Fact Sheet Publication Date (mm/yy) |
|---|---|---|---|---|---|
| | | | | | |

I have provided the patient with the appropriate documentation and information Initial: _____

**Clinician's name:** _____ **Clinician's signature:** _____

**Administration date:** _____ **Date EUA Fact Sheet and Vaccine card given to patient:** _____