Sierra County Public Health
COVID 19 Pfizer-BioNTech & Moderna Vaccination
Declaration and Consent

202 Front Street /P.O. Box 7 Loyalton, CA 96118 P:(530)993-6700 F:(530)993-6790 Email: Covid19@sierracounty.ca.gov

Name: (print) _____ **Date of Birth:** _____ **Gender:** M☐ F☐

Race: _____ **Ethnicity:** ☐ **Hispanic or** ☐ **Non-Hispanic** **Mothers First Name:** _____

Physical Address: _____ **Mailing Address:** _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____

Email: _____

FOR VACCINE RECIPIENTS:

If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain anything that you do not understand.

	Yes	No	Don't Know
1. Are you feeling sick today?	☐	☐	☐
2. Have you ever received a dose of Covid-19 vaccine?	☐	☐	☐
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?	☐	☐	☐
• Was the severe allergic reaction after receiving a COVID-19 vaccine?	☐	☐	☐
• Was the severe allergic reaction after receiving another vaccine or another injectable Medication?	☐	☐	☐
4. Do you have bleeding disorder or are you taking a blood thinner?	☐	☐	☐
5. Have you received passive antibody therapy as treatment for COVID-19?	☐	☐	☐
6. Have you received another vaccine in the last 14 days?	☐	☐	☐
7. Have you had a postive test for Covid-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
8. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
9. Are you pregnant or breastfeeding?	☐	☐	☐

_____ (initials) I HAVE RECEIVED AND READ COVID 19 Vaccine Screening Form for Contradictions and Precautions FOR THE EUA COVID 19 Vaccination. There was an opportunity to ask questions and my questions were answered satisfactorily. I understand the benefits and risks of the vaccine cited.

_____ (initials) I consent to a 15 minutes observation after receiving the EUA COVID 19 Vaccination.

_____ (initials) I consent to return for the second dose of the vaccine within the appropriate time frame.

_____ (initials) I have been informed of the vaccine associated risks with breastfeeding and pregnancy.

Consent to Receive the EUA COVID 19 Vaccine:

Signature: _____ **Date:** _____

Print Name Administered By: _____ Signature:_____ Date: _____

Administered Location: _____ **Address of Location:** _____

Dose #: ____ of _____ Left / Right

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