INDEPENDENCE
★MISSOURI★

COVID-19 Vaccination Consent under Emergency Use Authorization

PATIENT DEMOGRAPHIC INFORMATION

*Last Name:	*First Name:	Middle Initial:
*Date of Birth / /	*Sex: Male ☐ Female ☐ Non-binary ☐ Other ☐	
*Race White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ None Specified ☐ Refused ☐		Hispanic Ethnicity: Yes ☐ No ☐ Unknown ☐ Refused ☐
Address:		City:
State: Zip:	Home Phone:	Cell Phone:
County:	Email:	

	HEALTH HISTORY	YES	NO	UNKNOWN
1.	Are you feeling **sick today?**	☐	☐	☐
2.	Have you ever had a **severe allergic reaction** (e.g., anaphylaxis) **to something**? For example, a reaction for which you were treated with epinephrine or Epi Pen or for which you had to go to the hospital?	☐	☐	☐
3.	Have you ever had a **serious reaction after any vaccination** or injectable medication including a previous dose of the COVID-19 vaccine?	☐	☐	☐
4.	In the past 14 days have you had **contact with a confirmed COVID-19 patient?**	☐	☐	☐
5	Are you **breastfeeding** or **pregnant**?	☐	☐	☐
6.	Have you **received passive antibody therapy** as a treatment for COVID-19?	☐	☐	☐
7.	Are you **immunocompromised?** *(taking medication or being treated for cancer, leukemia, HIV/AIDS or other immune system problems or taking medication that affects your immune system)*	☐	☐	☐
8.	Do you have a **bleeding disorder** or are you **taking a blood thinner?**	☐	☐	☐
9.	Have you ever **received a dose of COVID-19 vaccine?**	☐	☐	☐

N.B.: Please be sure to fill and sign the Acknowledgement of Notice of Privacy Practices on the following page