*Your information about receiving the COVID -19 vaccine will be shared with the Ohio Statewide Immunization Registry, IMPACTSIIS.*

Assessment: Yes No Don’t Know

1. Are you currently ill or do you have a fever? 🞎 🞎 🞎
2. Have you received any vaccines in the past 14 days? 🞎 🞎 🞎
3. Any severe allergic reaction(s) (e.g. anaphylaxis)? 🞎 🞎 🞎
4. Any known allergic reaction to any component or 🞎 🞎 🞎

 excipient ingredient in this vaccine? (see Fact Sheet for Recipients and Caregivers)

1. Do you take any immunosuppressants? 🞎 🞎 🞎

 Short-term (less than 2 weeks) corticosteroid therapy

 or intra-articular, bursal, or tendon injections with corticosteroids

 should not be considered immunosuppressive.

1. Have you received either monoclonal antibodies and/or

 convalescent plasma in the past 90 days? 🞎 🞎 🞎

1. For women: Are you pregnant? 🞎 🞎 🞎

 Not been studied in Pregnancy, though not an exclusion. Consult with physician.

1. For women: Are you currently lactating? 🞎 🞎 🞎

Not been studied in Lactation though not an exclusion. Consult with physician.

1. Have you had the COVID-19 virus within the past 90 days? 🞎 🞎 🞎

I understand there is always a possibility of an adverse reaction to any vaccine/drug. All of my questions have been answered to my satisfaction. I understand the benefits and risks of the COVID-19 vaccine and expressly consent to administration. I have also received a copy of the Vaccine Information Sheet. On behalf of myself, my heirs, and representatives, I hereby release and hold harmless Muskingum Valley Health Centers, each applicable provider and staff from any and all liability or claims, whether known or unknown, in any way related to the vaccine administered.

Print Name: Date of Birth:

Signature: Date: