WAIANAE COAST COMPREHENSIVE HEALTH CENTER

86-260 FARRINGTON HIGHWAY
WAIANAE, HI 96792
(808) 697-3300

COVID-19 Vaccine Consent Form

Section 1: Information about Applicant (please print)

NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH: (m/d/yyyy)**
ADDRESS:			**BEST PHONE NUMBER(S) TO BE CONTACTED:**
CITY:	**STATE:**	**ZIP:**	
GENDER: M ☐ F ☐			**MRN:**
ETHNICITY: ***(CHOOSE ONE)*** [ ] HISPANIC OR LATINO [ ] NOT HISPANIC OR LATINO			**RACE:** ***(CHOOSE ONE)*** ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE ☐ UNKNOWN / NOT REPORTED

Section 2: Screening for Vaccine Eligibility
The following question will help us know if you can get the COVID-19 Vaccine. Please mark YES or NO for the question.

If you answer "YES" to following question, you can obtain the COVID-19 vaccine. If you answer "NO" to the following question, you may NOT be able to get the COVID-19 Vaccine and we will discuss your options.

	YES	**NO**
1. Have you reviewed and filled out the Prevaccination Checklist for COVID-19 Vaccines? :		

Section 3: Consent for Vaccination

I voluntarily consent to receive the COVID-19 Vaccine. I have read or had explained to me the COVID-19 Vaccine Information Statement (Equivalent) and understand the risks and benefits of this vaccine. I was offered the opportunity to ask questions which have been answered to my satisfaction. By my signature below I give my full consent to get vaccinated:

Signature:______________________________ Date: ____________________

Section 4: Permission to Release Information

I AUTHORIZE Waianae Coast Comprehensive Health Center (WCCHC) to use the information on this form for recordkeeping/tracking purposes. I may request a copy of this form to provide to my medical provider or I authorize WCCHC to release this information to my medical provider.

Signature:______________________________ Date: ____________________

Section 5: Reporting of Vaccine Information

You may voluntarily report any adverse events after receiving the vaccine to the Vaccine Adverse Event Reporting System (VAERS) online at vaers.hhs.gov or by calling 1-800-822-7967. You may also voluntarily participate in the CDC V-Safe after vaccination health checker app for the active safety monitoring of the vaccine.

Section 6: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	L/R Deltoid	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
COVID-19	/ /		1st			
COVID-19	/ /		2nd			

Vaccine Not Administered (Reason): ☐ **Contraindication** ☐ **Patient declined**
☐ **Other (describe):** ______________________________

Staff Name (please print): ______________________ **Staff Signature:** ______________________