DESOTO MEMORIAL HOSPITAL
900 N Robert Ave
Arcadia, FL 34266

CONSENT for COVID-19 VACCINATION

Patient Information			
Name:		Date of Birth:	
Address:	City:	State:	Zip:
Name of employer:			
Race: €American Indian/Alaska Native €Asian €Native Hamaiian/Other Pacific Islander €Black or African American €White €Other Race			
Ethnicity: €Hispanic €Not Hispanic or Latino €Unknown			
Gender: €Male €Female			
Is this patient's first or second dose of the COVID-19 vaccine? €First Dose €Second Dose Manufacturer of previous dose received:_____			
COVID-19 Screening and Vaccination Questions		**YES**	**NO**
Have you tested positive for COVID-19 in the past 30 days or are you currently being monitored for COVID-19?			
Have you had contact with anyone in the past 2 weeks who tested positive for COVID-19?			
Do you currently or have you in the past 2 weeks, had a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headaches, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?			
Are you sick right now with anything more than a mild illness?			
Do you have any history of allergic reactions? If so, please list.			
Have you had an allergic reaction to a previous dose of COVID-19 vaccine?			
Have you had any vaccines in the past 2 weeks?			
For women, are you pregnant or nursing?			

I have reviewed the EUA Fact Sheet for Recipients and Caregivers. I understand the risks and benefits of the vaccination. I understand that I must receive 2 doses of the vaccine 28 days apart to confer immunity and I know there is no absolute guarantee that I will become immune or that I will not have adverse reactions from the vaccine. I understand that I must be monitored for a minimum of 15 minutes after administration (30 minutes if history of anaphylaxis). I understand the COVID-19 vaccine is not approved by the FDA and I hereby give my consent to receive the COVID-19 vaccine. I release Desoto Memorial Hospital from all responsibilities for reactions that may occur from this immunization. ASSIGNMENT OF BENEFITS: I hereby authorize and assign payment directly to DeSoto Memorial Hospital of any insurance benefits otherwise payable to me for the administration of the COVID-19 vaccine.

(patient signature):_____Date:_____

Dose #: €1 OR €2 Site:_____ Route:_____Manufacturer:_____Lot #:_____

Exp Date:_____ Administered By: _____

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