PLEASE PRINT		
Last Name:	First Name:	Date of Birth:
Address:	City:	State: Zip:
Phone #:	Email:	
Patient ☐ Mason Health Staff ☐ Contracted Provider ☐ Volunteer ☐ Law Enforcement ☐ EMT ☐ Long Term Care Facility ☐ Long Term Care Staff ☐		Employee ID #/Department:

CONSENT TO MEDICAL TREATMENT: It is agreed that I, the patient, am under the care of my attending physician and the hospital is not liable for following the instructions of said physician. I consent to the procedures performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, anesthesia, or hospital services rendered to me as ordered by my physician or healthcare professional on the hospital's medical staff. I consent to have my blood tested for blood borne pathogens, including HIV, if there is an exposure of my body fluids to another person while I am in the hospital. I will have information about HIV made available to me should an exposure occur. I understand that as part of their training, students in healthcare education may participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the hospital, and that these students will be supervised by instructors, medical and hospital staff.

Disclosure of Records: Mason Health may be required to or may voluntarily disclose my health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries, for purposes of treatment, payment or health care operations.

1. Do you consider yourself to be of Latino or Hispanic origin? ☐ Yes ☐ No ☐ Decline to answer

2. What is your race?
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ White
   - ☐ Multi-Racial or other (please specify) _____
   - ☐ Decline to answer

3. Vaccine Dose (check one): 1st ☐ 2nd ☐ If this is your second dose, what vaccine was your first? Pfizer ☐ Moderna ☐ Don't know ☐ If this is your second dose, when did you receive your first dose? (date): _____.

	YES	NO
EXCLUSION QUESTIONS: Answering yes to either of these questions excludes you from receiving the vaccine.		
Do you have a known history of a severe allergic reaction (e.g. anaphylaxis) to this vaccine or any components of the vaccine such as lipids, potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate and sucrose? (Full list is available in the *Fact Sheet for Vaccine Recipients and Caregivers* or from your health care provider.)	☐	☐
Are you under the age of 16 years?	☐	☐
Are you under the age of 18 years?	☐	☐
SCREENING QUESTIONS: Immunizer: If patient answers "yes" to any of the below, provide patient counseling or instruct them to consult with their caregiver prior to receiving the vaccine		
1. In the past two weeks have you tested positive for COVID-19 or have you had a COVID-19 infection in the past 90 days?	☐	☐
2. In the past two weeks, have you had exposure to a person who tested positive for COVID-19 at a distance of 6 feet or less for a period of 15 or more minutes without wearing appropriate personal protective equipment?	☐	☐
3. In the past 90 days have you received passive antibody therapy as part of COVID-19 treatment?	☐	☐
4. Have you had the new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?	☐	☐

Patient Label

	YES	NO
5. Are you sick today? (For example, a cold or a fever or a new illness)	☐	☐
6. Do you have allergies or reactions to any foods, medicines, vaccines, or latex? (For example, eggs, gelatin, neomycin, thimerosal)	☐	☐
7. Have you ever had a serious reaction after receiving a vaccination or injectable medication? If yes, what vaccine or injectable medication: _____	☐	☐
8. Do you have a history of fainting, particularly with vaccines? Has any physician or other health care provider ever cautioned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	☐	☐
9. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	☐	☐
10. Do you take a blood thinner or anticoagulation medication? (For example, warfarin, Coumadin)	☐	☐
11. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (like diabetes), anemia, or other blood disorder?	☐	☐
12. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, or any other immune system problem?	☐	☐
13. Do you have a weakened immune system or in the past three months, taken medications that weaken it, such as cortisone, prednisone, or other steroids, anticancer drugs, or radiation treatments?	☐	☐
14. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin, or an antiviral drug?	☐	☐
15. For women, are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐
16. Have you received any vaccinations or TB skin test in the past four weeks?	☐	☐

☐ I have been provided with the Emergency Use Authorization sheet corresponding to the COVID-19 vaccine that I am receiving. I have read or had read to me the information provided about the COVID-19 vaccine and this Consent Form. I have had the chance to ask questions that were answered to my satisfaction. I understand the nature, alternatives, benefits and risks of vaccination. I understand the COVID-19 vaccine requires two doses and that as with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I have made the decision to receive the COVID-19 vaccine voluntarily and freely and I assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area or an area identified by my health care provider for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if I experience side effects that I should do the following: call Mason Health, my doctor, or call 911. I request that the vaccine be given to me or the stated person named above for whom I am authorized to make this request.

☐ I **do not** wish to receive the Covid-19 vaccine.

☐ I have already received the 2020-2021 Covid-19 vaccine. *Copy attached*.

Signature:	Date:
Follow-up Vaccine Appointment Date:	

For Office Use Only				
Vaccine:	Covid-19 Vaccine		**Date on VIS:**	☐ **1st Dose** ☐ **2nd Dose**
Date Given:	**Time Given:**		**Injection Site**	Left Right
Manufacturer, Lot #, Exp. Date			**Nurse Signature:**	
Patient Temperature:			**Date:**	

Patient Label

COVID-19 VACCINATION CONSENT

Mason Health, 901 Mountain View Dr.,
P.O. Box 1668, Shelton, WA 98584