Mass Vaccination Event Consent Form

Personal Information

Full Name

Date of Birth

Address

Phone Number

Email Address

Emergency Contact

Name

Phone Number

Relationship

Medical Information

Allergies

Current Medications

Medical Conditions

Vaccine Screening Questions

Have you received a COVID-19 vaccine before?

Are you feeling sick or feverish today?

Are you pregnant or breastfeeding?

Have you had a severe allergic reaction to a vaccine before?

Consent

I have read and understood the information provided. I consent to receive the vaccine.

Signature

Date