Harford County Health Department

Main Office: 120 S. Hays Street • P.O. Box 797 • Bel Air, Maryland 21014 • 410-838-1500

David M. Bishai MD, PhD • Health Officer
Marcy Austin • Deputy Health Officer

COVID-19 Vaccine Consent Form 2021

Please Print Information

By signing below, I agree that I have read or had explained to me the information on this form about the COVID-19 vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the COVID-19 vaccine and request that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

First Name			Middle Initial		

Last Name	Suffix	Mother's Maiden Name

Race	Hispanic/Latino	Occupation	Date of Birth	Age	Gender
	Yes ◯ No ◯				M ◯ F ◯ Other ◯

Email Address	Primary Phone Number

Address	City	State	Zip Code

Insurance Type
Private ◯ Medicaid/Medical Assistance ◯ Medicare ◯ No Insurance ◯

1.	Is this your first or second COVID-19 vaccination?	1st	2nd
2.	Do you have any chronic health conditions?	Yes	No
3.	Have you previously received a COVID-19 vaccine?	Yes	No
4.	Have you had a severe allergic reaction after receiving COVID-19 vaccine?	Yes	No
5.	Do you have a history of anaphylaxis or anaphylactic reaction after vaccination or other injectable medications, food, insect bites, venom, latex, or any other item?	Yes	No
6.	Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No
7.	Are you immunocompromised or are you taking medication that affects your immune system?	Yes	No
8.	Do you have a fever?	Yes	No
9.	Are you feeling sick?	Yes	No
10.	Are you pregnant?	Yes	No
11.	Could you become pregnant in the next several weeks?	Yes	No
12.	Are you breastfeeding (nursing)?	Yes	No
13.	Have you received any other vaccinations in the last 14 days?	Yes	No
14.	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	Yes	No

SIGNATURE (self/responsible party) ____ **DATE** ________________