VERIFIED ID _____ Johnson & Johnson Primary Series

Johnson & Johnson COVID-19 Vaccine Consent

Cedar County Public Health
400 Cedar St. Tipton, IA
(563) 886-2226

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	GENDER (circle one): Male Female Other

DATE OF BIRTH: ___ ___ / ___ ___ / ___ ___ ___ ___	AGE:	PHONE NUMBER:

STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

Any Known Allergies (Please list):

PLEASE ANSWER ALL QUESTIONS	CIRCLE ONE	
1. Have you previously received a dose of COVID-19 vaccine? If yes, was it Pfizer, Moderna, or Johnson & Johnson?	YES	NO
2. Are you sick today? (For example: a cold, fever, or acute illness)	YES	NO
3. In the past 14 days have you been diagnosed with COVID-19 or been in close contact with someone with COVID-19?	YES	NO
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	YES	NO
5. Are you allergic to any foods, medications, vaccines, or latex? (For example: polysorbate, stool softeners, etc.)	YES	NO
6. Have you ever had severe allergic reaction (anaphylaxis) requiring epinephrine, or for which you went to the hospital?	YES	NO
7. Do you have a bleeding disorder, history of blood clots, or are you taking a blood thinner?	YES	NO
8. Do you have a history of Guillain-Barré syndrome? (a rare syndrome that often causes muscle weakness and sometimes temporary paralysis.)	YES	NO
9. Does your provider consider you immunocompromised, or do you take medication that affects your immune system?	YES	NO

CONSENT FOR VACCINATION

- The Vaccine Information Sheet, or the Emergency use Authorization fact sheet have been made available to me and I understand the risks & benefits. I understand that this vaccine is not approved by the FDA, but is being offered under an FDA issued emergency use authorization.
- I give consent to Cedar County Public Health to vaccinate the person named above and to record the vaccination in the Iowa Immunization Registry Information System (IRIS).
- **I certify that the information I provided for payment and consent is correct.** I authorize release of all records required to act on this request. I authorize Medicare, Medicaid, Blue Cross Blue Shield, or other insurance to make payments directly to Cedar County Public Health.

Patient Signature: X _____ **Date:** _____

INSURANCE

INSURANCE COMPANY NAME:	UNINSURED ◯
IDENTIFICATION NUMBER:	
NAME OF CARD HOLDER:	BIRTH DATE OF CARD HOLDER: ___ ___ / ___ ___ / ___ ___ ___ ___

FOR OFFICE USE ONLY

◯ I have screened this patient for contraindications

◯ Left arm ◯ Right arm

Nurse's Signature: Date:

DOSE 1- IRIS	DOSE 1- NN	DOSE 1-BILLED

LOT #: