The Nevada Division of Public and Behavioral Health
COVID-19 Consent for Vaccination

Churchill County Public Health
485 West B Street, Suite 105
Fallon, Nevada 89406
Ph: 775-423-6695, option 2

Patient
Temp:

PATIENT INFORMATION: **Place of Employment: _____ Cell Number _____**

Last Name: _____ First Name: _____ DOB _____ AGE:____ Gender: _____

Address: _____City: _____State: _____ Zip Code:_____

Race (circle one): American Indian or Alaskan Native Asian Native Hawaiian/Other Pacific Islander
Black or African American White Other Race **Ethnicity (circle one):** Hispanic Non-Hispanic

Is this your **FIRST** or **SECOND** dose of the COVID-19 vaccination?

IMMUNIZATION SCREENING QUESTIONS:

1. Are you sick today **OR** have you had any symptoms of COVID-19, been in contact with someone with COVID-19 or tested Positive for Covid-19 in the past two weeks? **YES** **NO**
2. Do you have allergies or restrictions to foods, medications, vaccines or latex? **YES** **NO**
3. Have you ever had a serious reaction after receiving a vaccination? **YES** **NO**
4. Have you had a seizure or a brain or other nervous system problem or Guillain-Barre? **YES** **NO**
5. Do you take blood thinning medications? **YES** **NO**
6. Do you have a long-term health problem such as heart disease, lung, liver or kidney disease, metabolic disease (i.e. diabetes) anemia or other blood disorder? **YES** **NO**
7. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, Crohn's disease or any other immune system problem? **YES** **NO**
8. Do you have a weakened immune system or in the past 3 months taken any medications that weaken it such as cortisone, prednisone, or other steroids, anticancer drugs or radiation? **YES** **NO**
9. During the past year, have you received a transfusion of blood or blood products or been given Immune (gamma) globulin or an antiviral drug? **YES** **NO**
10. **FOR WOMEN:** Are you pregnant or breastfeeding? **YES** **NO**
11. Have you received any vaccinations or a TB skin test in the past 4 weeks? **YES** **NO**

Consent and Release Statement

I have received and understand the Vaccine Information Statement for vaccine to be administered to me or to the person named above, for whom I am authorized to make this request. I also agree to allow my immunization information, or the person named above, for whom I am authorized to make this request to be stored and accessed by users in Nevada's "WebIZ" computer system unless I indicate otherwise.

Signature, 18 or older, Parent / Guardian X _____ Date _____

VACCINE ADMINISTRATION INFORMATION (STAFF USE ONLY):

Vaccine:_____ Manufacturer: _____ Lot#: _____ Exp.: _____

VIS: _____ Route: _____ Site: _____ Volume (mL) _____

Nurse Signature: _____ Date: _____