Edward-Elmhurst HEALTHCARE | Healthy Driven

EEH Employee COVID Vaccine Consent (Pfizer/Moderna)

LAST NAME _____ **FIRST NAME**_____

DOB: ____/____/____ **EMPLOYEE ID NUMBER**_____

HOME ADDRESS_____ **PHONE**_____

Manufacturer: Pfizer or Moderna	**Yes**	**No**	**Don't Know**
Screening			
1. Do you currently have any symptoms of COVID, or any other illness, such as **fever**, cough, shortness of breath, sore throat, nausea, or diarrhea?			
2. In the past 90 days, have you tested positive for COVID-19?			
3. **IF #2 IS YES:** Did you receive convalescent plasma/ monoclonal antibodies?			
4. In the past 2 weeks, have you been in contact with anyone who tested positive for COVID-19?			
5. Have you ever had a reaction to a previous vaccine or injectable, including for COVID-19?			
6. Do you have a bleeding disorder or are you on a blood thinner?			
7. Have you received another dose of any COVID-19 vaccine? If yes: Date_____ Brand_____			
8. Have you received any vaccine in the past 14 days?			
9. Are you pregnant or breastfeeding, or do you plan to become pregnant?			

I give my permission to Edward-Elmhurst Health, on behalf of its affiliates providing healthcare services (e.g., Edward Hospital, Elmhurst Hospital, Edward Health Ventures) ("EEH") to administer the COVID-19 Vaccine to me. I understand that EEH relies on the health information provided by me above in administering the Vaccination. I understand that EEH, its employees, and physicians are not responsible for any negative effects of the vaccination due to inaccurate or incomplete information provided by me. I understand that receiving the vaccine is not required by, and not a condition of my employment with, EEH**.** I understand that receipt of this vaccine requires I opt in to the Illinois Comprehensive Automated Immunization Registry Exchange (ICare). ***I certify that I have read, understand, and have been provided a copy of the current Emergency Use Authorization and/or Information Sheet for this vaccine which explains the purpose, side effects, and possible complications of this vaccine and that after review of such documents, I consent to the administration of the COVID-19 Vaccine.***

Patient Signature _____ **Date** _____