Edward-Elmhurst HEALTHCARE | Healthy Driven

EEH COVID Vaccine Consent (Pfizer/ Moderna)

NAME:_____ **DOB:** ____/____/____

STREET ADDRESS:_____

CITY/ STATE: _____**PHONE:**_____

Are you an Edward-Elmhurst Employee? _____ **Employee ID Number:** _____

Manufacturer: Pfizer	**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. **IF #2 IS YES:** Were you diagnosed with Multisystem Inflammatory Syndrome?			
5. In the past 2 weeks, have you been in contact with anyone who tested positive for COVID-19?			
6. Have you ever had a reaction or fainted following a previous vaccine or injectable, including for COVID-19?			
7. Do you have a bleeding disorder or are you on a blood thinner?			
8. Have you received another dose of any COVID-19 vaccine? If yes: First Dose Date_____ Brand_____ Second Dose Date_____ Brand_____			
9. Are you pregnant or breastfeeding, or do you plan to become pregnant?			
10. Have you had myocarditis or pericarditis (inflammation of the heart or heart lining)?			
11. Are you immunocompromised?			

I give my permission to Edward-Elmhurst Health, on behalf of its affiliates providing healthcare services (e.g., Edward Hospital, Elmhurst Hospital, Linden Oaks 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 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** _____

Updated August 24, 2021