SILVER CROSS HOSPITAL

☐ **Check here if you are NOT a Silver Cross Employee**

Patient Label

2020-2021 COVID-19 VACCINE CONSENT FORM AND ADMINISTRATION RECORD

NAME	EMPLOYEE# (IF APPLICABLE)
DEPARTMENT	POSITION
DATE OF BIRTH	TEMPERATURE
SOCIAL SECURITY NUMBER:	EMAIL ADDRESS:
HOME ADDRESS:	
BEST PHONE NUMBER TO REACH YOU:	

Your health and well-being are of the utmost importance, and we are taking measures to keep the facility a safe environment for employees as well as our visitors. Please answer the following screening questions:

QUESTION	YES	NO
Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms:		
Fever (100.4F oral temp or greater)		
Shortness of breath or difficulty breathing		
Cough		
Have you tested positive for COVID-19 in the past 90 days?		
In the past 14 days, have you been in close contact, without use of PPE, with someone who is currently sick with, suspected or confirmed, COVID-19		
Do you feel ill today?		
Do you have any immune deficiency disease?		
Have you ever had a serious allergic reaction and/or do you carry an epi-pen?		
Are you currently pregnant or breastfeeding?		
Have you received another vaccine in the past 14 days?		
Have you received the COVID-19 vaccine before?		
Did you have problems with a previous COVID-19 shot other than arm pain?		
If yes, what was the brand of last COVID-19 vaccination?		
If yes, what was date of last COVID-19 vaccination?		

I understand that this vaccine has not been FDA approved, but was given Emergency Use Authorization by the FDA. I have been provided Emergency Use Authorization information and have had explained to me the COVID-19 Vaccine Information Statement about COVID-19 and the COVID-19 vaccine. I have had a chance to read the information and ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and consent to receiving the vaccine. Lastly, I attest that I am eligible to receive the vaccine under the current Illinois/Will County distribution phase.

Signature ____________________ Date ____________ Employee# (if applicable) ____________

Vaccine Administered: Type: Lot#: Expiration: Dose: Route:

Date Administered: ____________________ Site (circle) R L Deltoid

Printed name of vaccinator ____________________ Signature of vaccinator ____________________

CNT122
51277

REMINDER:
Your second dose of COVID-19 vaccine is due on: ____________________

WHITE - Chart YELLOW - Patient

CC1000-REV 2/21