DHCHD
Dallam Hartley Counties
Hospital District

1411 Denver Avenue
Dalhart, Texas 79022
www.dhchd.org

COVID-19 VACCINE CONSENT

Personal Information (PLEASE PRINT)

NAME: _____ **DOB:** _____

Home Address:_____

_____

I have read or have had explained to me the Vaccine Information Statement about the COVID vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me.

SIGNATURE: _____ DATE: _____

PLEASE CIRCLE YOUR ANSWER TO THE FOLLOWING QUESTIONS:

1. Are you sick today? NO YES
2. Have you ever had a serious reaction or fainted after receiving any vaccination? NO YES
3. Do you have a serious allergy to ANY medications or food? NO YES
4. Do you have a seizure disorder or brain disorder? NO YES
5. Are you pregnant or are you considering becoming Pregnant in the next month? NO YES
6. Do you have a medical condition or take medication(s) that may weaken your **immune system**? If yes, please list: _____ NO YES
7. In the past two weeks, have you tested positive for COVID-19? NO YES
8. In the past two weeks, have you had contact with anyone who tested positive for COVID-19? NO YES
9. Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea? NO YES
10. Are you quarantined now? NO YES

Location of Immunization (please choose preference): **ARM: L R** **HIP: L R**