Fond du Lac County Health Department

City/County Government Center
160 S. Macy St., Fond du Lac, WI 54935
Phone: 920-929-3085 | Fax: 920-929-3102 | www.fdlco.wi.gov

Johnson&Johnson COVID-19 VACCINE CONSENT FORM

Please Print

Name: ____
Date of Birth: _______________ Telephone__________________________
Home Address: ____
City: ____
State:_________ County:____________________ Zip Code:_____________
Email: ____

Screening Questions

Do not administer if the answer is NO

1. Are you over the age of 18? Yes No

Do not administer if the answer is YES

3. Do you feel ill today, or do you have a fever? Yes No
COVID-19 Symptoms: T >/=100.0 F, respiratory symptoms (cough, shortness of breath), or new loss of smell and/or taste, headache, sore throat or muscle pain

4. Have you received COVID Convalescent Plasma (CCP) and/or Monoclonal antibody therapy for COVID (mAB): Bamlanivimab or Regeneron Cocktail in the past 90 days? (if yes, need to defer vaccine for 90 days from receipt of these therapies) Yes No

5. Have you received any other vaccinations in the past 14 days? (if yes, need to wait 14 days from receipt of another vaccine) Yes No

6. Have you tested positive for COVID-19 in the past 10 days? Yes No

7. *History of severe allergic reaction (e.g., anaphylaxis) after a previous dose of a COVID-19 vaccine or any of its components? Yes No

8. *History of an immediate allergic reaction of any severity to a previous dose of a COVID-19 vaccine or any of its components? (include polyethylene glycol (PEG) Yes No

9. *History of immediate allergic reaction of any severity to polysorbate? Yes No

*Should not receive the COVID-19 vaccination at this time unless they have been evaluated by an allergist-immunologist and it is determined whether the person can safely receive the vaccine (e.g., under observation, in a setting with advanced medical care available).

Special Considerations - Prior consult with health care provider, is not a requirement for vaccination

10. For women, are you pregnant or breastfeeding? Yes No

11. Are you immunocompromised or on a medication that effects your immune system? Yes No

Monitor if YES

12. Do you have a condition that makes you bruise or bleed easily? (if yes, monitor for bleeding post vaccination) Yes No

13. History of an immediate allergic reaction of any severity to a vaccine or injectable therapy (intramuscular, intravenous, or subcutaneous or therapies not related to components of the COVID-19 vaccine or polysorbate) or a history of anaphylaxis due to any cause? (**if yes, should be observed for 30 minutes**) Yes No

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Updated 1/18/2021

I hereby certify that the foregoing history is true and complete to the best of my knowledge. I understand that this COVID-19 vaccine is authorized for emergency use and is not approved by the FDA. I have received and read the "Emergency Use Authorization Fact Sheet for Recipients and Caregivers" and have had an opportunity to ask questions. The known and potential risks and benefits of the vaccine, as well as available alternatives, have been explained to me. I understand that I can accept or refuse the vaccine.

I hereby consent to the administration of the COVID-19 vaccine.

Signature: ____ **Date:** _______________

Print Name: ____

OFFICE USE ONLY

Type of Vaccine	Dosage	Lot #	Expiration Date	Dose Number
Janssen COVID-19 Vaccine	**0.5ml**			**1**

Site: (Intramuscular Injection) Left Deltoid ________ Right Deltoid ________

Vaccine Administrator Signature: ____

Vaccine Administrator Printed Signature____

Date Given:_____________ **Vaccine Information Provided: Yes No**