BP-A1136
MAR 2022

COVID-19 VACCINE CONSENT - INMATE

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

(PRINT) Inmate Name (Last, First)	**Register Number**	**Institution**

I have been provided a copy of the FDA COVID-19 fact sheet dated _____. I have had the opportunity to ask questions about the benefits and risks of vaccination, including if I am pregnant, breastfeeding, or have a weakened immune system to include taking immunosuppressive drugs. I have been informed that mRNA vaccines are preferred over the Janssen vaccine because of the risk of thrombosis with thrombocytopenia syndrome following receipt of the Janssen vaccine.

Health Questions Prior to COVID-19 Vaccination (*Check yes or no*)

Yes	No	Health Questions
☐	☐	Are you sick today?
☐	☐	Do you have a bleeding disorder or take a blood thinner?
☐	☐	Have you ever had a severe allergy (i.e., anaphylaxis) ***OR*** an immediate allergic reaction of any severity to any component of this vaccine (i.e., PEG, polysorbate), a previous dose of this vaccine, or any other vaccine/injectable therapy?
☐	☐	Have you ever had myocarditis or pericarditis (inflammation of the heart muscle or its lining)?
☐	☐	Have you ever had multisystem inflammatory syndrome (persistent fever and severe inflammation) due to COVID-19 or after COVID-19 vaccination?
		For the **Janssen (Johnson & Johnson)** vaccine only:
☐	☐	Have you ever had Guillain-Barré syndrome (progressive paralysis)?
☐	☐	Have you had thrombosis (blood clotting) with thrombocytopenia (low platelets)?
☐	☐	**Have you ever received a dose of COVID-19 vaccine? If yes, which one?** ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another product **How many doses?** _____ **Date of last dose**: _____

☐ I consent to receive the COVID-19 vaccination.

Inmate Signature:	**Date:**
Administered by Signature/Credentials:	**Date:**
(PRINT) Administered by Name/Credentials:	

☐ I decline to receive the COVID-19 vaccination.

☐ I have already been vaccinated with ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)*
☐ Another product How many doses? _____ Date of last dose: _____

☐ Other reason: _____

Inmate Signature:	**Date:**
Witness Signature/Credentials:	**Date:**
(PRINT) Witness Name/Credentials:	

COVID-19 Vaccine Information

Dose # (1, 2, 3, or booster)	Vaccine Manufacturer	Lot Number	Expiration Date	Route	Deltoid
				IM	☐ Left ☐ Right

BP-A1136
MARZO 2022

CONSENTIMIENTO PARA LA APLICACIÓN DE LA VACUNA CONTRA LA COVID-19 - RECLUSOS

DEPARTAMENTO DE JUSTICIA DE LOS ESTADOS UNIDOS **AGENCIA FEDERAL DE PRISIONES**

(EN IMPRENTA) Nombre del recluso (apellido, nombre)	**Número de registro**	**Institución**

Se me ha entregado una copia de la hoja informativa de la vacuna COVID-19 con fecha _____. He tenido la oportunidad de hacer preguntas sobre los beneficios y riesgos de la vacuna, incluyendo preguntas respecto de si estoy embarazada, amamantando, o tengo un sistema inmunitario debilitado para incluir la toma de medicamentos inmunosupresores. Se me ha informado que las vacunas de ARNm son preferidas sobre la vacuna de Janssen debido al riesgo de trombosis con síndrome de trombocitopenia después de recibir la vacuna de Janssen.

Preguntas relacionadas con la salud antes de la aplicación de la vacuna contra la COVID-19 ***(marcar "Sí o No").***

Sí	**No**	**Preguntas relacionadas con la salud**
☐	☐	¿Está enfermo hoy?
☐	☐	¿Tiene un trastorno hemorrágico o toma un anticoagulante?
☐	☐	¿Alguna vez ha sufrido algún tipo de alergia grave (anafilaxia, por ejemplo) **o** una reacción alérgica inmediata de algún tipo ante alguno de los componentes de esta vacuna (es decir, polietilenglicol, polisorbato) a una dosis previa de la misma **o** algula otra vacuna/terapia inyectable?
☐	☐	¿Alguna vez has tenido miocarditis o pericarditis (inflamación del músculo cardíaco o su revestimiento)?
☐	☐	¿Alguna vez has tenido síndrome inflamatorio multisistés (fiebre persistente e inflamación severa) debido al COVID-19 o después de la vacuna de COVID-19?
		Solo para la vacuna de Janssen (Johnson & Johnson):
☐	☐	¿Alguna vez has tenido el síndrome de Guillain-Barré (parálisis progresiva)?
☐	☐	¿Ha tenido trombosis (coagulación de la sangre) con trombocitopenia (plaquetas bajas)?
☐	☐	**¿Alguna vez ha recibido una dosis de la vacuna COVID-19? En caso afirmación, ¿cuál?** ☐ Pfizer-BioNTech ☐ Moderna ☐Janssen (*Johnson & Johnson*) ☐ Otro producto **¿Cuántas dosis?** _____ **Fecha de la última dosis:** _____

☐ **Doy mi consentimiento para recibir la vacuna contra la COVID-19.**

Firma del recluso:	**Fecha:**
Firma del administrador/credenciales:	**Fecha:**
Administrado por nombre/credenciales:	

☐ **Me niego a recibir la vacuna contra la COVID-19.**

☐ Ya he sido vacunado con ☐ Pfizer-BioNTech ☐ Moderna ☐Janssen (*Johnson & Johnson*)
☐ Otro product ¿Cuántas dosis? _____ Fecha de la última dosis: _____

☐ Otra razón: _____

Firma del recluso:	**Fecha:**
Firma del testigo/credenciales:	**Fecha:**
(EN LETRA DE IMPRENTA) Nombre del testigo y credenciales:	

Información sobre la vacuna COVID-19

Dosis n.º (1, 2, 3 o refuerzo)	**Fabricante de la vacuna**	**Número de lote**	**Fecha de vencimiento**	**Ruta**	**Deltoides**
				IM	☐ Izquierdo ☐ Derecho

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COVID-19 VACCINE CONSENT – EMPLOYEES

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

I have been provided a copy of the FDA COVID-19 fact sheet dated _____. I have had the opportunity to ask questions about the benefits and risks of vaccination, including if I am pregnant, breastfeeding, or have a weakened immune system to include taking immunosuppressive drugs. I have been informed that mRNA vaccines are preferred over the Janssen vaccine because of the risk of thrombosis with thrombocytopenia syndrome following receipt of the Janssen vaccine.

Health Questions Prior to COVID-19 Vaccination (*Check yes or no*)

Yes	No	Health Questions
☐	☐	Are you sick today?
☐	☐	Do you have a bleeding disorder or take a blood thinner?
☐	☐	Have you ever had a severe allergy (i.e., anaphylaxis) ***OR*** an immediate allergic reaction of any severity to any component of this vaccine (i.e., PEG, polysorbate), a previous dose of this vaccine, or any other vaccine/injectable therapy?
☐	☐	Have you ever had myocarditis or pericarditis (inflammation of the heart muscle or its lining)?
☐	☐	Have you ever had multisystem inflammatory syndrome (persistent fever and severe inflammation) due to COVID-19 or after COVID-19 vaccination?
		For the **Janssen (Johnson & Johnson)** vaccine only:
☐	☐	Have you ever had Guillain-Barré syndrome (progressive paralysis)?
☐	☐	Have you had thrombosis (blood clotting) with thrombocytopenia (low platelets)?
☐	☐	**Have you ever received a dose of COVID-19 vaccine? If yes, which one?** ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)* ☐ Another product **How many doses?** _____ **Date of last dose:** _____

☐ **I consent to receive the COVID-19 vaccination.**

Employee Signature:	**Date:**
Administered by Signature/Credentials:	**Date:**
(PRINT) Administered by Name/Credentials:	

☐ **I decline to receive the COVID-19 vaccination.**

☐ I have already been vaccinated with ☐ Pfizer-BioNTech ☐ Moderna ☐ Janssen *(Johnson & Johnson)*
☐ Another product How many doses? _____ Date of last dose: _____

☐ Other reason: _____

Employee Signature:	**Date:**
Witness Signature/Credentials:	**Date:**
(PRINT) Witness Name/Credentials:	

COVID-19 Vaccine Information

Dose # (1, 2, 3, or booster)	Vaccine Manufacturer	Lot Number	Expiration Date	Route	Deltoid
				IM	☐ Left ☐ Right

(PRINT) Employee Name (Last, First)	Date of Birth	Institution