BP-A1136
FEB 21

# COVID-19 VACCINE CONSENT - INMATE

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

I have been provided a copy of the COVID-19 Vaccine **Emergency Use Authorization (EUA)** 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. I will agree to complete the number of vaccine doses as appropriate and indicated by the manufacturer.

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

| Yes | No | Health Questions |
|---|---|---|
| ☐ | ☐ | Are you sick today? |
| ☐ | ☐ | Have you ever had a severe allergy (i.e., anaphylaxis) or an immediate allergic reaction of any severity to any component of this vaccine or to a previous dose of this vaccine? |
| ☐ | ☐ | Have you ever had an immediate allergic reaction to any other vaccine/injectable therapy? |
| ☐ | ☐ | Have you had any other vaccinations in the last 14 days? |
| ☐ | ☐ | Have you received monoclonal antibody therapy for COVID-19 in the last 90 days? |

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

| Dose # (1 or 2) | Vaccine Manufacturer | Lot Number | Expiration Date | Route | Deltoid |
|---|---|---|---|---|---|
| | | | | **IM** | ☐ Left ☐ Right |

| Inmate Signature | Date |
|---|---|
| | |
| **Administered by Signature** | **Date** |
| | |
| **Administered by (name/title)** | |
| | |

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

| Inmate Signature | Date |
|---|---|
| | |
| **Witness Signature** | **Date** |
| | |
| **(PRINT) Witness Name** | |
| | |

| (PRINT) Inmate Name (Last, First) | Register Number | |
|---|---|---|
| | | |
| **Institution** | **Unit** | **Work Assignment** |
| | | |

**DOCUMENT VACCINE ADMINISTRATION IN BEMR FLOW SHEETS**
**SCAN VACCINE CONSENT IN BEMR DOCUMENT MANAGER – VACCINATION CONSENT**

Se me ha entregado una copia de la ficha informativa de la **Autorización de Uso de Emergencia (EUA, Emergency Use Authorization)** de la vacuna contra la 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. Accederé a recibir el número correspondiente de dosis de la vacuna tal como sea indicado por su fabricante.

**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? |
| ☐ | ☐ | ¿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 **o** a una dosis previa de la misma? |
| ☐ | ☐ | ¿Alguna vez ha tenido alguna reacción alérgica inmediata a otra vacuna o terapia inyectable? |
| ☐ | ☐ | ¿Ha recibido alguna otra vacuna en los últimos 14 días? |
| ☐ | ☐ | ¿Ha recibido terapia de anticuerpos monoclonales contra la COVID-19 en los últimos 90 días? |

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

| Dosis n.º (1 o 2) | Fabricante de la vacuna | Número de lote | Fecha de vencimiento | Ruta | Deltoides |
|---|---|---|---|---|---|
| | | | | | ☐ Izquierdo<br>☐ Derecho |
| **Firma del recluso** | | | | | **Fecha** |
| | | | | | |
| **Firma del administrador** | | | | | **Fecha** |
| | | | | | |
| **Administrado por (nombre/cargo)** | | | | | |
| | | | | | |

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

| **Firma del recluso** | **Fecha** |
|---|---|
| | |
| **Firma del testigo** | **Fecha** |
| | |
| **(EN LETRA DE IMPRENTA) Nombre del testigo** | |
| | |

| **(EN IMPRENTA) Nombre del recluso** (apellido, nombre) | **Número de registro** | |
|---|---|---|
| | | |
| **Institución** | **Unidad** | **Asignación de trabajo** |
| | | |

**DOCUMENT VACCINE ADMINISTRATION IN BEMR FLOW SHEETS**
**SCAN VACCINE CONSENT IN BEMR DOCUMENT MANAGER – VACCINATION CONSENT**

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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 COVID-19 Vaccine **Emergency Use Authorization (EUA)** 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. I will agree to complete the number of vaccine doses as appropriate and indicated by the manufacturer.

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

| Dose | Employee Signature | Witness Signature | Date |
|---|---|---|---|
| #1 | | | |
| #2 | | | |

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

| Dose #1 | | Dose #2 | | Health Questions |
|---|---|---|---|---|
| Yes | No | Yes | No | |
| ☐ | ☐ | ☐ | ☐ | Are you sick today? |
| ☐ | ☐ | ☐ | ☐ | Have you ever had a severe allergy (i.e., anaphylaxis) or an immediate allergic reaction of any severity to any component of this vaccine **or** to a previous dose of this vaccine? |
| ☐ | ☐ | ☐ | ☐ | Have you ever had an immediate allergic reaction to any other vaccine/injectable therapy? |
| ☐ | ☐ | ☐ | ☐ | Have you had any other vaccinations in the last 14 days? |
| ☐ | ☐ | ☐ | ☐ | Have you received monoclonal antibody therapy for COVID-19 in the last 90 days? |

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

☐ I have already been vaccinated by my private provider.
☐ I plan to be vaccinated by my private provider.
☐ Other reason: _____

| Employee Signature | Witness Signature | Date |
|---|---|---|
| | | |

## COVID-19 Vaccine Information

| Dose | Date | Vaccine Manufacturer | Lot Number | Expiration Date | Route | Deltoid | Administered by (name/title): |
|---|---|---|---|---|---|---|---|
| #1 | | | | | IM | ☐Left ☐Right | |
| #2 | | | | | IM | ☐Left ☐Right | |

| (PRINT) Employee Name (Last, First) | Year of Birth | Institution |
|---|---|---|
| | | |