

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
<input type="checkbox"/>	<input type="checkbox"/>	Are you sick today?
<input type="checkbox"/>	<input type="checkbox"/>	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?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an immediate allergic reaction to any other vaccine/injectable therapy?
<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/> Left <input type="checkbox"/> Right
Inmate Signature				Date	
Administered by Signature				Date	
Administered by (name/title):					

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

☐ I have already been vaccinated.

☐ Other reason: _____

Inmate Signature	Date
Witness Signature	Date
(PRINT) Witness Name	

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