

COVID-19 Vaccination Consent Form

Adults (18+ Years)

The **COVID-19 vaccination consent form** sample for adults is designed to ensure individuals provide informed permission before receiving the vaccine. It includes essential information about the vaccine, potential side effects, and affirmation of understanding. This form helps streamline the vaccination process while protecting both patients and healthcare providers.

Personal Information

Full Name:

Date of Birth:

Address:

Phone Number:

Email (optional):

Health Information

Are you currently feeling ill or experiencing any symptoms of COVID-19?

Have you ever had a serious reaction to any vaccine or injectable medication?

Are you pregnant or breastfeeding? (If applicable)

Any other relevant medical conditions or allergies?

Vaccine Information

I have been provided with information about the COVID-19 vaccine, including its benefits, risks, and potential side effects such as pain at the injection site, fever, fatigue, headache, nausea, etc. I understand that serious side effects are rare but may include allergic reactions.

Consent and Acknowledgement

☐

I have read and understood the information provided about the COVID-19 vaccine. I have had the opportunity to ask questions, and they have been answered to my satisfaction.

☐

I voluntarily consent to receive the COVID-19 vaccination.

Signature:

Date:

Submit