



Covid-19 Vaccine Dose #2 Questionnaire

接種新冠疫苗同意書

1.	Did you have any severe reactions to the first dose of Covid-19 vaccine within 24 hours? 您接種了第一劑新冠 Covid-19 疫苗 24 小時內有任何嚴重反應嗎?	<input type="checkbox"/> Yes 有	<input type="checkbox"/> No 沒有	<input type="checkbox"/> Unknown 不知道
2.	Did you have: Hives, itchiness, flushing or pallor of skin 你有沒有: 蕁麻疹, 皮膚瘙癢, 潮紅或皮膚蒼白	<input type="checkbox"/> Yes 有	<input type="checkbox"/> No 沒有	<input type="checkbox"/> Unknown 不知道
3.	Did you have: Swollen tongue or throat, constriction of your airway, wheezing or trouble breathing 你有沒有: 舌頭或喉嚨腫脹, 呼吸道狹窄, 喘息或呼吸困難	<input type="checkbox"/> Yes 有	<input type="checkbox"/> No 沒有	<input type="checkbox"/> Unknown 不知道
4.	Did you have: Low blood pressure (hypotension) 你有沒有: 低血壓	<input type="checkbox"/> Yes 有	<input type="checkbox"/> No 沒有	<input type="checkbox"/> Unknown 不知道
5.	Did you have: Weak or rapid pulse 你有沒有: 微弱或快速脈搏	<input type="checkbox"/> Yes 有	<input type="checkbox"/> No 沒有	<input type="checkbox"/> Unknown 不知道
6.	Did you have: Dizziness or fainting 你有沒有: 頭暈或暈厥	<input type="checkbox"/> Yes 有	<input type="checkbox"/> No 沒有	<input type="checkbox"/> Unknown 不知道
7.	Did you have: Nausea, vomiting or diarrhea 你有沒有: 噁心, 嘔吐或腹瀉	<input type="checkbox"/> Yes 有	<input type="checkbox"/> No 沒有	<input type="checkbox"/> Unknown 不知道

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

Signature of Patient or Personal Representative	Print Name	Date