COVID-19 VACCINE CONSENT
AND ACKNOWLEDGEMENT FORM

INFORMATION ABOUT YOU (PLEASE PRINT)

Name: Last: First: Middle Initial:

Date of Birth: Month Day Year **Social Security Number:**

Address: **Phone Number:**

City: **State:** **Zip:**

Sex (Gender assigned at birth)
☐ Female
☐ Male

Race
☐ American Indian or Alaska Native ☐ Native Hawaiian or other ☐ Other Asian ☐ Unknown
☐ Asian ☐ Pacific Islander ☐ Other Nonwhite
☐ Black or African American ☐ White ☐ Other Pacific Islander

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Veteran Status: ☐ Yes ☐ No

Primary Language:

Primary Insurance Carrier ID #:_____ Grp #: _____
Insurance Company :_____ Insurance Company Phone #_____
Insured's Name:_____ Relationship:_____ Insured's Date of Birth_____
Secondary Insurance Carrier ID #:_____ Grp #: _____
Insurance Company :_____ Insurance Company Phone # _____
Insured's Name:_____ Relationship:_____ Insured's Date of Birth_____

Phase 1B/1C/1D 2A/ 2B: Eligibility date: Beginning March 11th, 2021
Eligibility criteria: The following group of Ohioans are included, even though they are not age 50 or older, because they were born with or developed in childhood a severe condition that puts them at very high risk for dying from COVID-19.

The following group of Ohioans are eligible for vaccination because they were born with or developed in childhood a severe condition that puts them at very high risk for dying from COVID-19. Those conditions are:
Sickle cell anemia
Cystic fibrosis
Cerebral Palsy
People born with severe heart defects requiring regular specialized medical care.
Phenylketonuria (PKU), Tay-Sachs disease, and other rare, inherited metabolic disorders.
Turner syndrome, fragile X syndrome, Prader-Willi syndrome, and other severe genetic disorders.
Alpha and beta thalassemia.
Down Syndrome.
Muscular dystrophy.
Spina bifida.
People with severe type 1 diabetes, who have been hospitalized in the past year.
Epilepsy with continuing seizures; hydrocephaly; microcephaly and other sever neurological disorders.
People with severe asthma, who have been hospitalized for this in the past year.
Solid organ transplant candidates or recipients.

☐ **I confirm that I have one of the medical conditions listed above, and I am eligible to receive a vaccination as part of Ohio's Phase 1B Vaccination Program**.

TARGET POPULATION/OCCUPATION
What group are you in?

Phase 1B
☐ Individuals over 80 years of age
☐ Individuals age 75 to 79 years of age
☐ Individuals age 70 to 74 years of age
☐ Individuals age 65 to 69 years of age
☐ Individuals with Congenital Disorders or Early Onset Conditions with IDD
☐ Individuals working in K-12 schools
☐ Individuals with Congenital Disorders or Early in Life Conditions that Carried into Adulthood without IDD

Phase1C
☐ Type 1 diabetes
☐ Pregnant women
☐ Bone marrow transplant recipients
☐ ALS (Lou Gehrig's Disease)
☐ Childcare Services
☐ Funeral Services
☐ Law Enforcement, Firefighters and Corrections

Phase 1D
☐ Type 2 diabetes
☐ End-stage renal disease

Phase 2
Phase 2A
☐ Individuals age 60 to 64 years of age
Phase 2B
☐ Individuals age 50 and older

OFFICE USE ONLY VACCINE NAME: COVID-19

MANUFACTURER
☐ Moderna (MOD) ☐ AstraZeneca (ASZ) ☐ Johnson & Johnson (JNJ) ☐ Novavax
☐ Pfizer (PFR) ☐ GlaxoSmithKline ☐ Merck ☐ Sanofi

DOSE IN SERIES
☐ First
☐ Second

DATE OF VACCINATION
_____/_____/_____

ROUTE OF ADMIN
☒ IM ☐ TD ☐ IV ☐ NS
☐ SC ☐ID ☐O ☐Other

SITE OF INJECTION
☐ RA ☐ RD ☐RT ☐Other
☐ LA ☐ LD ☐LT _____

SERIES COMPLETE?
☐ Yes
☐ No

VACCINATOR

CONSENT FOR COVID-19 VACCINATION (PLEASE READ)

- I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the ONE Health Ohio (ONE) or its agents to administer the COVID-19 vaccine.
- I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 to 30 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless ONE, and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
- I acknowledge that: (a) I understand the purposes/benefits of Impact SIIS Ohio's immunization registry and (b) DOH will include my personal immunization information in Impact SIIS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize ONE or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to ONE or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if ONE invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the Notice of Privacy Rights.

COVID-19 VACCINE INFORMATION

☐ Prevaccination Checklist for COVID-19 Vaccines (English)

☐ Prevaccination Checklist for COVID-19 Vaccines (Spanish)

☐ Pfizer-BioNTech COVID-19 Vaccine EUA Fact Sheet (English)

☐ Pfizer-BioNTech COVID-19 EUA Fact Sheet (Spanish)

☐ Moderna COVID-19 Vaccine EUA Fact Sheet (English)

☐ Moderna COVID-19 Vaccine EUA Fact Sheet (Spanish)

☐ Janssen COVID-19 EUA Fact Sheet (English)

☐ Janssen COVID-19 Vaccine EUA Fact Sheet (Spanish)

What to Expect after Receiving a COVID-19 Vaccine

V-Safe Information Sheet

I have read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian). You have received a copy of the appropriate COVID-19 VACCINE INFORMATION.

I UNDERSTAND I MUST TO WAIT FOR 15 to 30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING

Signature of Patient or Authorized Representative: _____

Printed Name of Representative: _____

Relationship to Person Receiving Vaccine: _____

Date: _____