COVID-19 VACCINE CONSENT
AND ACKNOWLEDGEMENT FORM

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_____

TARGET POPULATION/OCCUPATION / What group are you in?
Phase 1B/1C/1D/1E/2A/2B/2C/2D: Eligibility updated: Beginning March 29th, 2021
Please Select One Group below:

☐ Assisted Living Facility Resident
☐ Assisted Living Facility Staff
☐ Skilled Nursing Facility Resident
☐ Skilled Nursing Facility Staff
☐ State of Ohio DODD Resident
☐ State of Ohio DODD Staff
☐ State of Ohio Veterans Home Resident
☐ State of Ohio Veterans Home Staff
☐ State of Ohio MHAS Resident
☐ State of Ohio MHAS Staff
☐ State of Ohio DRC LTC Resident
☐ State of Ohio DRC LTC Staff
☐ Congregate Care Facility Resident
☐ Congregate Care Facility Staff
☐ Hospital worker Clinical Staff
☐ Hospital worker Administrative Staff

☐ Hospital worker Ancillary Staff
☐ Non-Hospital healthcare worker Clinical Staff
☐ Non-Hospital healthcare worker Administrative Staff
☐ Non-Hospital healthcare worker Ancillary Staff
☐ Emergency Medical Services EMTs/Paramedics
☐ 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
☐ Diabetes Type 1
☐ Pregnant

☐ Bone Marrow Transplant Recipient
☐ ALS
☐ Childcare Services Worker
☐ Funeral Services Worker
☐ Law Enforcement, Corrections, Firefighter
☐ Diabetes Type 2
☐ End Stage Renal Disease
☐ Cancer
☐ Chronic Kidney Disease
☐ Chronic Obstructive Pulmonary Disease
☐ Heart Disease
☐ Obesity
☐ Individuals age 60 to 64 years of age
☐ Individuals age 50 to 59 years of age
☐ Individuals age 40 to 49 years of age
☐ Individuals age 16 to 39 years of age

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 16 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.
- All patients receiving the Covid vaccine will be billed an administration charge to their insurance. There will be no out of pocket charges or copays. Patients without insurance will be submitted to the Health Resources & Services Administration (HRSA) program and will not incur out of pocket charges or copays.
- 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.

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: _____