



# COVID-19 VACCINE CONSENT AND ACKNOWLEDGEMENT FORM

<b>Name:</b> Last: _____ First: _____ Middle Initial: _____		
<b>Date of Birth:</b> Month _____ Day _____ Year _____		<b>Social Security Number:</b> _____
<b>Address:</b> _____		<b>Phone Number:</b> _____
<b>City:</b> _____	<b>State:</b> _____	<b>Zip:</b> _____
<b>Sex</b> (Gender assigned at birth) <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Race</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other <input type="checkbox"/> Other Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other Nonwhite <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other Pacific Islander	<b>Ethnicity</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
<b>Veteran Status:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Primary Language:</b> _____
<b>Primary Insurance Carrier ID #:</b> _____ <b>Grp #:</b> _____		
Insurance Company : _____ Insurance Company Phone # _____		
Insured's Name: _____ Relationship: _____ Insured's Date of Birth _____		
<b>Secondary Insurance Carrier ID #:</b> _____ <b>Grp #:</b> _____		
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 29 <sup>th</sup> , 2021		
<b>Please Select One Group below:</b>		
<input type="checkbox"/> Assisted Living Facility Resident <input type="checkbox"/> Assisted Living Facility Staff <input type="checkbox"/> Skilled Nursing Facility Resident <input type="checkbox"/> Skilled Nursing Facility Staff <input type="checkbox"/> State of Ohio DODD Resident <input type="checkbox"/> State of Ohio DODD Staff <input type="checkbox"/> State of Ohio Veterans Home Resident <input type="checkbox"/> State of Ohio Veterans Home Staff <input type="checkbox"/> State of Ohio MHAS Resident <input type="checkbox"/> State of Ohio MHAS Staff <input type="checkbox"/> State of Ohio DRC LTC Resident <input type="checkbox"/> State of Ohio DRC LTC Staff <input type="checkbox"/> Congregate Care Facility Resident <input type="checkbox"/> Congregate Care Facility Staff <input type="checkbox"/> Hospital worker Clinical Staff <input type="checkbox"/> Hospital worker Administrative Staff	<input type="checkbox"/> Hospital worker Ancillary Staff <input type="checkbox"/> Non-Hospital healthcare worker Clinical Staff <input type="checkbox"/> Non-Hospital healthcare worker Administrative Staff <input type="checkbox"/> Non-Hospital healthcare worker Ancillary Staff <input type="checkbox"/> Emergency Medical Services EMTs/Paramedics <input type="checkbox"/> Individuals over 80 years of age <input type="checkbox"/> Individuals age 75 to 79 years of age <input type="checkbox"/> Individuals age 70 to 74 years of age <input type="checkbox"/> Individuals age 65 to 69 years of age <input type="checkbox"/> Individuals with congenital disorders or early onset conditions with IDD <input type="checkbox"/> Individuals working in K-12 schools <input type="checkbox"/> Individuals with Congenital Disorders or Early in Life Conditions that Carried into Adulthood without IDD <input type="checkbox"/> Diabetes Type 1 <input type="checkbox"/> Pregnant	<input type="checkbox"/> Bone Marrow Transplant Recipient <input type="checkbox"/> ALS <input type="checkbox"/> Childcare Services Worker <input type="checkbox"/> Funeral Services Worker <input type="checkbox"/> Law Enforcement, Corrections, Firefighter <input type="checkbox"/> Diabetes Type 2 <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Chronic Obstructive Pulmonary Disease <input type="checkbox"/> Heart Disease <input type="checkbox"/> Obesity <input type="checkbox"/> Individuals age 60 to 64 years of age <input type="checkbox"/> Individuals age 50 to 59 years of age <input type="checkbox"/> Individuals age 40 to 49 years of age <input type="checkbox"/> Individuals age 12 to 39 years of age

OFFICE USE ONLY VACCINE NAME: COVID-19			
<b>MANUFACTURER</b> <input type="checkbox"/> Moderna (MOD) <input type="checkbox"/> AstraZeneca (ASZ) <input type="checkbox"/> Johnson & Johnson (JNJ) <input type="checkbox"/> Novavax <input type="checkbox"/> Pfizer (PFR) <input type="checkbox"/> GlaxoSmithKline <input type="checkbox"/> Merck <input type="checkbox"/> Sanofi		<b>DOSE IN SERIES</b> <input type="checkbox"/> First <input type="checkbox"/> Second	<b>DATE OF VACCINATION</b> _____ / _____ / _____
<b>ROUTE OF ADMIN</b> <input checked="" type="checkbox"/> IM <input type="checkbox"/> TD <input type="checkbox"/> IV <input type="checkbox"/> NS <input type="checkbox"/> SC <input type="checkbox"/> ID <input type="checkbox"/> O <input type="checkbox"/> Other	<b>SITE OF INJECTION</b> <input type="checkbox"/> RA <input type="checkbox"/> RD <input type="checkbox"/> RT <input type="checkbox"/> Other <input type="checkbox"/> LA <input type="checkbox"/> LD <input type="checkbox"/> LT _____	<b>SERIES COMPLETE?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>VACCINATOR</b> _____

## 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 SIIIS Ohio's immunization registry and (b) DOH will include my personal immunization information in Impact SIIIS 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 Vaccine EUA Fact Sheet \(Spanish\)](#)

[Moderna COVID-19 Vaccine EUA Fact Sheet \(English\)](#)

[Moderna COVID-19 Vaccine EUA Fact Sheet \(Spanish\)](#)

[Janssen COVID-19 Vaccine 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: \_\_\_\_\_