BOOSTER
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_____

Pre-Screening Questions	**Yes**	**No**	**Don't Know**
1. Are you feeling sick today?			
2. Date you received your second dose of the COVID-19 Vaccine. **Month:** **Date:** **Year:**			
• Which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product _____			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of a COVID-19 vaccine including either of the following:			
○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids.			
• A previous dose of COVID-19 vaccine.			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			

5. Check all that apply to you:

☐ Am a female between ages 18 and 49 years old
☐ Am a male between ages 12 and 29 years old
☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
☐ Have a weakened immune system (i.e., HIV infection, cancer)
☐ Take immunosuppressive drugs or therapies
☐ Have a bleeding disorder
☐ Take a blood thinner
☐ Have a history of heparin-induced thrombocytopenia (HIT)
☐ Am currently pregnant or breastfeeding
☐ Have received dermal fillers
☐ History of Guillain-Barre Syndrome (GBS)

Reviewed by: **Date:**

Staff Use Only

☐ **Pfizer (PFR) BOOSTER**

DATE OF VACCINATION _____/_____/_____

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

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

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: _____