



COVID-19 VACCINE CONSENT for THIRD and BOOSTER DOSES

Name: Last: _____		First: _____		Middle Initial: _____			
Date of Birth: Month _____		Day _____		Year _____			
Address: _____				Social Security Number: _____			
City: _____				Phone Number: _____			
State: _____		Zip: _____					
Sex (Gender assigned at birth) <input type="checkbox"/> Female <input type="checkbox"/> Male		Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Nonwhite <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other Pacific Islander			Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		
Veteran Status: <input type="checkbox"/> Yes <input type="checkbox"/> 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-Vaccination Checklist for COVID-19 Vaccines					Yes	No	Don't Know
1. Are you feeling sick today?							
2. Have you ever received a dose of COVID -19 vaccine?					Month:	Date:	Year:
<ul style="list-style-type: none"> • Which vaccine product did you receive? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another product _____ • Have you received a complete COVID vaccine series? 							
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.)							
<ul style="list-style-type: none"> • A component of a COVID-19 vaccine including either of the following: <ul style="list-style-type: none"> <input type="checkbox"/> Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures <input type="checkbox"/> 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:							
<input type="checkbox"/> Am a female between ages 18 and 49 years old							
<input type="checkbox"/> Am a male between ages 12 and 29 years old							
<input type="checkbox"/> Have a history of myocarditis or pericarditis							
<input type="checkbox"/> Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies							
<input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum							
<input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection							
<input type="checkbox"/> Have a bleeding disorder							
<input type="checkbox"/> Take a blood thinner							
<input type="checkbox"/> Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies							
<input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT)							
<input type="checkbox"/> Am currently pregnant or breastfeeding							
<input type="checkbox"/> Have received dermal fillers							
<input type="checkbox"/> History of Guillain-Barre Syndrome (GBS)							
Staff Use Only Reviewed by:							
<input type="checkbox"/> Pfizer BOOSTER <input type="checkbox"/> Pfizer 3rd DOSE <input type="checkbox"/> Moderna 3rd DOSE <input type="checkbox"/> Moderna 3rd BOOSTER				VACCINATION DATE: _____ / _____ / _____			
ROUTE OF ADMIN <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		SITE OF INJECTION <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 _____		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 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

- | | |
|--|--|
| <input type="checkbox"/> Prevaccination Checklist for COVID-19 Vaccines (English) | <input type="checkbox"/> Prevaccination Checklist for COVID-19 Vaccines (Spanish) |
| <input type="checkbox"/> Pfizer-BioNTech COVID-19 Vaccine EUA Fact Sheet (English) | <input type="checkbox"/> Pfizer-BioNTech COVID-19 Vaccine EUA Fact Sheet (Spanish) |
| <input type="checkbox"/> Moderna COVID-19 Vaccine EUA Fact Sheet (English) | <input type="checkbox"/> Moderna COVID-19 Vaccine EUA Fact Sheet (Spanish) |
| <input type="checkbox"/> Janssen COVID-19 Vaccine EUA Fact Sheet (English) | <input type="checkbox"/> 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 attest that I meet all criteria to receive Third or Booster Dose of the COVID-19 vaccine. 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). I have received a copy of the appropriate COVID-19 VACCINE INFORMATION/FACT SHEET.

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 Patient or Authorized Representative: _____

Relationship to Person Receiving Vaccine: _____

Date: _____