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)	**Race**	**Ethnicity**
☐ Female ☐ Male	☐ 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	☐ 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__________________

This Section for STAFF USE ONLY	
Pre-Screening Questions Reviewed by:	**Date Reviewed:**
☐ **Moderna ages 6 months through 17 years**	**Primary:** ☐ **First** ☐ **Second**
☐ **Moderna BOOSTER ages 18 years through 49 years**	**Booster:** ☐ **First Booster**
☐ **Moderna BOOSTER ages 50 years and older**	**Booster** ☐ **First Booster** ☐ **Second Booster**
☐ **Moderna (immunocompromised) ages 6 months through 17 years**	**Primary:** ☐ **First** ☐ **Second** ☐ **Third**
☐ **Moderna (immunocompromised) BOOSTER ages 18 years and older**	**Booster:** ☐ **First Booster** ☐ **Second Booster**
☐ **Pfizer ages 12 years and older**	**Primary:** ☐ **First** ☐ **Second**
☐ **Pfizer BOOSTER ages 5 years through 49 years**	**Booster:** ☐ **First Booster**
☐ **Pfizer BOOSTER ages 50 and older**	**Booster:** ☐ **First Booster** ☐ **Second Booster**
☐ **Pfizer (immunocompromised) ages 12 years and older**	**Primary:** ☐ **First** ☐ **Second** ☐ **Third**
☐ **Pfizer (immunocompromised) BOOSTER 12 years and older**	**Booster:** ☐ **First Booster** ☐ **Second Booster**
Route of Admin: ☒ IM ☐ TD ☐ IV ☐ NS ☐SC ☐ID ☐O ☐Other	**Site of Injection:** ☐ RA ☐ RD ☐RT ☐Other ☐ LA ☐ LD ☐LT ______________________
Vaccinator:	**Vaccination Date:**

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 Fact Sheet 6mon - 5yrs (English)

☐ Moderna Covid-19 Fact Sheet 6mon - 5yrs (Spanish)

☐ Moderna COVID-19 EUA Fact Sheet 6 yrs.-11 yrs.(English)

☐ Moderna COVID-19 EUA Fact Sheet 6yrs.-11yrs.(Spanish)

☐ Moderna COVID-19 EUA Fact Sheet (English)

☐ Moderna COVID-19 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 WAIT FOR 15 to 30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING

Signature of Patient, Parent or Authorized Representative: ______________________________

Printed Name of Patient, Parent or Authorized Representative: ______________________________

Relationship to Person Receiving Vaccine: ______________________________

Date: ____________________