COVID-19 Vaccine Consent

First Name: _____ Last Name: _____ Middle Initial: _____

DOB: _____ Address: _____

Phone Number: _____ Email: _____

What is your gender? ○ Male ○ Female What is your ethnicity? ○ Hispanic ○ Not Hispanic

What is your race (check all that apply)?
○ American Indian/Alaska Native ○ Asian ○ Black or African American ○ White ○ Other Pacific Islander ○ Native Hawaiian

Do you have Insurance? ○ Yes ○ No If yes: ○ Medicaid ○ Medicare ○ Other Private Insurance

	YES	NO
1. Are you feeling sick today?		
2. Have you seen a medical provider within the last 14 days? If yes, for what?_____		
3. Have you received a vaccination within the last 14 days?		
4. Have you ever received a dose of COVID-19 vaccine? ○ Pfizer ○ Moderna ○ Another Product		
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen, or for which you had to go to the hospital?		
5(a). Was the severe allergic reaction after receiving a COVID-19 vaccination?		
5(b). Was the severe allergic reaction after receiving another vaccine or another injectable medication?		
6. Do you have a bleeding disorder or are you taking a blood thinner?		
7. Have you received passive antibody therapy (convalescent plasma) as treatment for COVID-19?		

I understand that if I answer "yes" to any of the above conditions, I could be at increased risk of having a negative reaction or problem from the vaccine. I further declare that if I have any of the following conditions, I have had the opportunity to speak with my primary care provider and am making an informed decision to receive the vaccine:

1. Pregnant, attempting to become pregnant or breastfeeding;
2. Have a bleeding disorder or are on a blood thinner;
3. Are immunocompromised or are taking medication that affects the immune system (such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; HIV/AIDS, cancer, leukemia, ankylosing spondylitis or radiation treatments).

I agree to wait in or near the clinic location for a minimum of 15 minutes after receiving the vaccine. If I have previously had a severe allergic reaction to a vaccine or injectable medication, I agree to wait in or near the clinic for a minimum of 30 minutes after receiving the vaccine.

I understand that the COVID-19 vaccine is a two-part vaccine series. By signing this consent, I am agreeing that I will receive the first and second part of the vaccine series.

I understand that the COVID-19 vaccine has been authorized by the Federal Food and Drug Administration (FDA) under an Emergency Use Authorization (EUA), and, at this time, there is not enough scientific evidence available for the FDA to fully approve any COVID-19 vaccine.

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I understand that the common risks associated with the COVID-19 vaccine include, but are not limited to, pain, redness or swelling at the site of injection, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, feeling unwell or swollen lymph nodes (lymphadenopathy). I understand that the vaccine may cause a severe allergic reaction which can include anaphylaxis (difficulty breathing, swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness). I understand that these may not be all the side effects of the COVID-19 vaccine as the vaccine is still being studied in clinical trials. I also understand that it is not possible to predict all possible side effects or complications which could be associated with the vaccine. I understand that the long-term side effects or complications of this vaccine are not known at this time.

I understand that the vaccination is being given by Community Health Connection, Inc (CHC). The owner and/or operator of this organization, their affiliates, officers, directors, employees, and agents expressly disclaim any responsibility for the vaccination. My consent is given in light of this knowledge, and in consideration of CHC giving the COVID-19 vaccine. I, for myself and my heirs, administrators, trustees, executors, assigns, and successors in interest do hereby agree to release and hold harmless CHC, its subsidiaries, divisions, affiliates, successors, assigns, directors, officers, trustees, employees, volunteers, and agents from and against any and all demands, damages, losses, costs, expenses, obligations, liabilities, claims, actions, and cause of action (whether any of which is groundless or otherwise) of any nature whatsoever (including, without limitation, reasonable attorney's fees and court costs) by reason of or resulting, in any way, from any and all acts, accidents, events, occurrences, omissions and the like related to, or arising out of, directly or indirectly, my receipt of this COVID-19 vaccine. CHC makes no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness for a particular purpose regarding the vaccine or its effectiveness.

I have read and understood the "Fact Sheet for Recipients and Caregivers" regarding the COVID-19 vaccination. I further understand and agree that CHC is required to submit COVID-19 vaccine administration data to the Oklahoma State Immunization Information System (OSIIS), and report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System

I understand and agree to all of the above and I hereby give my consent to the staff of CHC to give me a COVID-19 vaccine.

Signature	Date
Print Name	Date

Vaccine Lot Number and Expiration Date	Route	Administered by (legal signature and title)
Lot #_____ Expiration Date:_____	IM ○ RD ○ LD	

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