Patient COVID-19 VACCINE – Consent and Release

Completed by Patient/Representative	
Full Name	
Date of Birth	
Age	
Date	

COVID-19

COVID-19 is a highly contagious respiratory disease caused by SARS-CoV-2 virus. It is thought to spread from person to person through droplets released when an infected personal coughs, sneezes or speaks. It may also be spread by touching a surface with the virus on it and then touching one's mouth, nose, or eyes. Some people may not have any symptoms but are still able to spread the virus. Most people recover without needing special treatment. Others are at higher risk of serious illness. Those at higher risk include older adults and people with serious medical problems, such as heart or lung disease, diabetes, cancer or a weak immune system. Serious illness may include life threatening pneumonia and organ failure.

COVID-19 VACCINE BENEFITS

Although the efficacy of COVID-19 vaccines is uncertain at present and will not be known with certainty for some time, this vaccine may help prevent you from getting COVID-19. The benefits are detailed on the attached Fact Sheet from the vaccine manufacturer.

COVID-19 VACCINE RISKS AND POSSIBLE SIDE EFFECTS

The risks and possible side effects of this vaccine are detailed on the Fact Sheet. Pregnant women, women who are breastfeeding, people who are immunocompromised, and people who have had an allergic reaction to *any* vaccine in the past need to consult with their physicians before receiving the vaccine.

ELIGIBILITY

Please respond to the following questions to determine eligibility for vaccination.

	QUESTIONS	YES	NO
1.	Are you sick today? Do you have a fever?		
2.	Have you received any vaccinations in the past two weeks and/or have you received any other COVID-19 vaccine at any time?		
3.	Have you been diagnosed with COVID-19 infection in the last 90 days?		
4.	Have you ever had an allergic reaction to any of the components of the COVID-19 vaccine? The components are listed in the attached Fact Sheet.		
5.	Have you ever had an anaphylactic reaction (e.g. trouble breathing, broke out in hives, had facial or tongue swelling, had low blood pressure), or had other severe symptoms after receiving another vaccination or shot?		
6.	Do you have a history of an anaphylactic reaction to anything other than a vaccine or shot (such as a reaction to food, insect stings, or oral medication)?		
7.	Do you have a bleeding disorder or do you take a blood thinner?		
8.	Do you have a history of a weakened immune system?		
9.	Is it possible that you are or may become pregnant in the next four weeks, or are you currently breastfeeding?		
10.	Are you age 17 or younger?		
11.	Are you immunocompromised or are you on a medicine that affects your immune system?		

I have read and understand this Consent and Release form as well as the attached Fact Sheet. I have had an opportunity to ask questions, which were answered to my satisfaction.

I understand that the vaccine will be given in two separate doses.

I understand the known risks and the potential benefits of receiving the vaccine, and I understand there may be risks to the vaccine that are not known at this time. I understand that the FDA has authorized use of the vaccine under an Emergency Use Authorization (EUA) and that there is currently not enough scientific evidence available for the FDA to fully approve this or any other COVID-19 vaccine. I nonetheless request and consent to the vaccine being given to me.

I understand it is recommended that I remain on site after receiving the vaccine to monitor for signs of an allergic reaction.

I understand that data about my vaccination will become a part of my Owensboro Health medical record and may be used or disclosed as permitted by HIPAA and detailed in our Notice of Privacy Practices, including to local, state, or federal agencies for public health or research purposes.

I AGREE TO RELEASE AND HOLD HARMLESS OWENSBORO HEALTH, ITS OFFICERS, DIRECTORS, TEAM MEMBERS, AND AGENTS FROM ANY AND ALL LIABILITY ARISING FROM OR CONNECTED WITH VACCINE STORAGE, HANDLING, OR ADMINISTRATION, INCLUDING BUT NOT LIMITED TO INJURIES FROM INJECTION, ADVERSE REACTIONS TO THIS VACCINE, OR IF THIS VACCINE DOES NOT PROTECT ME FROM COVID-19.

Name (Printed): _____

_____	_____	_____	_____
Signature of Patient/Parent/Guardian/Power of Attorney	Relationship	Date	Time

_____	_____	_____
Witness	Date	Time