COVID-19 VACCINE CONSENT FORM- 2nd and Booster Dose

Patient Name: _____ Patient DOB: _____

Today's date: _____

- 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 18 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to Langley Health Services 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 (for the Moderna and Janssen vaccines; 16 years of age and older for the Pfizer vaccine); 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 understand that the Moderna and Pfizer vaccines are a two-dose series vaccine. If given a first dose of the Moderna vaccine, I will need to receive the 2nd dose of the Moderna vaccine at 28 days from the first dose. If given a first dose of the Pfizer vaccine, I will need to receive the 2nd dose the Pfizer vaccine at 21 days from the first dose. If I receive the Johnson & Johnson vaccine, I will only need one vaccine dose.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation (or 30 minutes if I have a history of severe allergic reactions). 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 Langley Health Services (LHS) 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 Florida SHOTS, Florida's immunization registry and (b) LHS will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize LHS 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 LHS 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 LHS invoices me after the time of service, upon receipt of such invoice. I acknowledge receipt of the Notice of Privacy Rights.

Signature of Patient or Authorized Representative: _____ Date: _____

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

Today's Date:

Pre-vaccination Checklist for COVID-19 Vaccines

To be completed on day of vaccination

Patient Name: _____ **Patient DOB: _____**

For vaccine recipients: The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider or clinical staff member to explain it.

	Yes	No	Don't Know
Are you feeling sick today?	◯	◯	◯
Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product did you receive? ◯ Pfizer ◯ Moderna ◯ Janssen (Johnson & Johnson) ◯ Another product If yes, did you bring your vaccination record card or other documentation?	◯ ◯	◯ ◯	◯

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 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
	◯	◯	◯

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 caused hives, swelling, or respiratory distress, including wheezing.)*	◯	◯	◯

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
◯Have a history of myocarditis or pericarditis
◯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)
◯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)

Signature of Patient or Authorized Representative: _____ **Date: _____**

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

For office use only

IM Route Site	Dose	Manufacturer (MVX)	Lot # Unit of Use/ Unit of Sale	Expiration Date	Date of EUA Fact Sheet
☐ Left ☐ Right		☐ Janssen ☐ Moderna ☐ Pfizer			

Vaccine Administrator Signature: _____ **Date: _____**