Ascension

COVID-19 Vaccine Acknowledgement and Consent Form

Recipient Information (Please Print Clearly)

Last Name:	First Name:	Date of Birth:
Home Address:		Phone:
City:	State:	Zip:

The following questions will help us determine whether you can receive 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 must be asked. If a question is not clear, please ask a staff member for further explanation:

	Yes	No	N/A
1. Are you 18 years of age or older? If no, how old are you?_____	❑	❑	
2. Are you feeling sick today?	❑	❑	
3. 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 _____	❑	❑	❑
4. Have you ever had an allergic reaction* to any of the following:			
• A component of the COVID-19 vaccine	❑	❑	
• Polysorbate	❑	❑	
• A previous dose of COVID-19 vaccine	❑	❑	
5. Have you ever had an allergic reaction* to another vaccine (other than COVID-19 vaccine) or an injectable medication?	❑	❑	
6. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	❑	❑	
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	❑	❑	
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	❑	❑	
9. Have you been diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) within the last 90 days?	❑	❑	
10. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	❑	❑	
11. Do you have a bleeding disorder or are you taking a blood thinner?	❑	❑	
12. For women: Are you pregnant or breastfeeding?	❑	❑	❑
13. Have you experienced an episode of immune-mediated syndrome characterized by thrombosis (blood clot) and thrombocytopenia (low platelets)?	❑	❑	

*An allergic reaction includes 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.

I consent to administration of a COVID-19 vaccination and acknowledge and agree with the following statements:

- The U.S. Food and Drug Administration (FDA) has authorized emergency use of the COVID-19 vaccines, which are not currently FDA-approved. At this time, there is no FDA approved vaccine to prevent COVID-19.
- I have received the Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers (the "Fact Sheet") and have read it or have it read to me.
- Some versions of the COVID-19 vaccine require two (2) identical doses by the same manufacturer in order to be effective. I understand that I will be informed at the time of vaccination whether I will need a second dose. If a second dose is required, I understand that I am responsible for scheduling an appointment for my second dose in accordance with the timeframe outlined in the Fact Sheet.
- I understand the known and potential risks and benefits to the COVID-19 vaccine and the extent to which such benefits and risks are unknown.
- I acknowledge that I have the option to refuse vaccination and have been informed of any available alternatives to the COVID-19 vaccine and the risks and benefits of available alternatives.
- Recipients who are Pregnant or Breastfeeding: Pregnant and breastfeeding persons were not included in the clinical trials for COVID-19 vaccines. I have discussed the potential risks of COVID-19 infection versus the risk of vaccination with my healthcare provider and have made the informed decision to receive a COVID-19 vaccine.
- I understand that it is recommended that I remain at the vaccination clinic for fifteen (15) minutes following administration of the vaccine for observation (the "Monitoring Period") to ensure I do not experience an adverse reaction. Recipients that have a history of severe allergic reactions should be monitored for thirty (30) minutes post vaccination.
- I acknowledge that I have received information on V-safe, a voluntary smartphone based tool operated by the Centers for Disease Control and Prevention (CDC). Through V-safe, vaccine recipients can report any side effects of the COVID-19 vaccine to the CDC. This information helps CDC monitor the safety of COVID-19 vaccines in near real time.
- I authorize Ascension or its agents to submit a claim to my insurance provider for administration of the COVID-19 vaccine. I understand that I will have no out of pocket cost or cost sharing associated with receiving the vaccine. I acknowledge I was offered the Notice of Privacy Practices, which is also available at healthcare.ascension.org/NPP.
- I have had the opportunity to ask questions which have been answered to my satisfaction.

If you experience an adverse reaction to the COVID-19 vaccine, please contact your primary care provider or present to the nearest emergency department. If you are experiencing a medical emergency, call 911.

Signature of Recipient/Authorized Representative:	Date:
Print:	
If signed by Authorized Representative, please state relationship to Recipient:	

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Vaccine Administrator (Print Name):
Administration Date/Date Fact Sheet Provided:

Manufacturer	Lot Number	Expiration Date	Site of Administration

❒ Monitoring Period completed and no adverse reaction noted.

❒ Recipient declined Monitoring Period. Waiver completed.

Signature of Observer: _____

❒ COVID-19 Acknowledgement and Consent Form and Monitoring Period Waiver (if applicable) uploaded to PureOHS *(for recipients who are Ascension associates, contractors, or medical staff members only)* or the native EHR (*for recipients who are Ascension patients).*