Summit County Public Health

INJECTABLE

NAME: Last Name, First Name		DATE OF BIRTH		AGE	SEX
ADDRESS: Number and Street	**CITY**	**STATE**	**ZIP CODE**		**PHONE NUMBER**
RACE		**ETHNICITY**			

CONSENT

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent of the minor patient or legal guardian of the patient; or (c) acting at the request of the patient named above. Further, I hereby give my consent to each licensed healthcare provider to administer the COVID-19 vaccine and share my personal, demographic, and health condition information to determine eligibility and to satisfy reporting requirements of the Centers for Disease Control and Prevention (CDC) or other federal agencies.

I understand that this product has not been approved or licensed by the Food and Drug Administration (FDA), but has been authorized for emergency use by the FDA, under an Emergency Use Authorization (EUA) to prevent Coronavirus Disease 2019 (COVID-19); 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 if this vaccine requires two doses, then two doses of this vaccine will need to be administered (given) for it to be effective.

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 I have received, read and/or had explained to me the EUA 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 minutes (or more in specific cases) after administration for observation. Life threatening allergic reactions to vaccines are very rare. Signs of a serious allergic reaction include: shortness of breath, hoarseness and wheezing, hives, paleness, weakness, elevated heart rate, or severe dizziness. These symptoms may occur within a few minutes, or up to 48 hours after the vaccination. If you are experiencing any of these symptoms, you should contact a healthcare provider immediately. 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 the State of Ohio, the Ohio Department of Health (ODH), and each licensed healthcare providers 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 assign and transfer any monies or benefits for administering the vaccine to the licensed healthcare provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

SIGNATURE (Self, Parent, Guardian) : **DATE:**

FOR CLINIC/OFFICE USE ONLY. **NOTES:**	**CLINIC DATE**	**CLINIC SITE**	**VACCINE INFO**	**SITE OF INJECTION**

Photo ID Presented and Reviewed Name on Health Insurance Card Matches Photo ID

Staff Name:

Signature/Title of Vaccine Administrator:

revised: 04-19-2021

FRONT (Please fill out other side)

Pre Vaccination Checklist	NO	Don't Know	YES
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
● If yes, which vaccine product?			
3. 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 occurred within 4 hours 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.			
● A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			
4. 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 occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.			
6. Have you received another vaccine in the last 14 days?			
7. Have you 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. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			
12. Do you have dermal fillers?			
SIGNATURE (Self, Parent, Guardian) : **DATE**:			

BACK