RUSH MEMORIAL HOSPITAL

COVID-19 Pfizer Vaccine Consent

To be completed by individual receiving the COVID-19 Vaccine – *(Please Print)*

Last Name: _____ First Name: _____ Date of Birth: _____

Please let your vaccinator know if you:

1. Have a condition or take a medication that makes you bruise or bleed easily (discuss with your provider if you have concerns): or
2. Have a history of a severe allergy and/or have an epinephrine auto-injector.

Please answer the following questions:

Answers to questions #1, #2 and #3 must be "Yes" or "Not Applicable (N/A)" to proceed.

* **Note for individuals under the age of 18:** *Individuals age 16 or older are eligible to receive the Pfizer COVID-19 vaccine. Individuals who are age 16 or 17 require parental/guardian consent to receive the Pfizer COVID-19 vaccine.*

1. Are you 16 or older? (*vaccinator must verify DOB above and confirm eligibility to receive the vaccine being administered*)	*Yes*	*No*	
2. Are you feeling well today, and do you have a bodily temperature below 100°F?	Yes	No	
3. If you are pregnant or breastfeeding, have you discussed the COVID-19 vaccine with your provider?	Yes	No	N/A

If you answer "Yes" to question #5, #6, #7, #8, or #9 you may be asked to delay or not receive the vaccine at this time.

4. Have you ever received a dose of COVID-19 vaccine?	Yes	No	
5. Have you had an allergic reaction* after receiving a dose of the COVID-19 vaccine? * reaction such as itching, skin flushing, swelling of face, lips, tongue, shortness of breath, wheezing, rapid heart rate, low blood pressure.	Yes	No	N/A
6. Have you had an allergic reaction* to products containing polyethylene glycol (such as laxatives like MiraLAX/Golytely)? * reaction such as itching, skin flushing, swelling of face, lips, tongue, shortness of breath, wheezing, rapid heart rate, low blood pressure.	Yes	No	
7. Have you received any other vaccines within the past 14 days?	Yes	No	
8. Have you ever had an allergic reaction* to a vaccine or any other injectable therapy? * reaction such as itching, skin flushing, swelling of face, lips, tongue, shortness of breath, wheezing, rapid heart rate, low blood pressure.	Yes	No	
9. In the past 90 days, have you received antibody treatment for COVID-19?	Yes	No	

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COVID-19 – Survey Verification and Consent to Receive Vaccination

I hereby certify that the information I provided is complete, true and accurate to the best of my knowledge. I understand that the falsification or misrepresentation of any of the information, or the failure or neglect to disclose any of the information, may be grounds for termination from this vaccination program, regardless of when such falsification, misrepresentation, failure or neglect may be discovered.

I understand that the COVID-19 vaccine has been approved for use and is being administered pursuant to an Emergency Use Authorization issued by the FDA. I hereby certify that I have received and have read the "Emergency Use Authorization Fact Sheet for Recipients and Caregivers" and have had the chance to ask questions and had them answered to my satisfaction.

I consent to the administration of the COVID-19 vaccination, a 2-dose series, with doses separated by an interval recommended by the vaccine manufacturer. I understand the risks and benefits of vaccination and I voluntarily assume full responsibility for any reactions that may result.

I understand and AGREE to remain in the vaccine administration area for 15 minutes after receiving vaccination to be monitored for any potential adverse reactions (30 minutes if I have had a severe allergic reaction to anything in the past). I understand that if I experience side effects after leaving the vaccine location, that – depending on the severity of the reaction – I should contact my healthcare provider and/or 911. If I am unsure if my reaction is severe, I understand that I should err on the side of caution and call 911. I understand and acknowledge that after receiving the COVID-19 vaccine I still need to follow the guidance in my workplace, including the wearing of the correct personal protective equipment and taking part in any required screening programs.

I understand and agree that information related to my receipt of the COVID-19 vaccine may be disclosed by Rush Memorial Hospital to state immunization registries and other governmental authorities as required by law or by procedures related to COVID-19 vaccine distribution and administration tracking.

_____ _____

Signature of individual to receive vaccine (or parent, guardian, or authorized representative) | Date

If signing on behalf of the individual receiving the vaccine, you are stating that you are authorized to provide the required consent on behalf of that individual. And, that you will monitor the individual receiving the vaccine for any adverse reactions.

Name of parent, guardian, or authorized representative	Relationship	Phone Number

Verbal Consent Granted: Yes No

Name of parent, guardian, or authorized representative	Relationship	Phone Number

Witness Signature	Title	Date

Witness Signature	Title	Date