Vaccine Consent Form For COVID-19 Vaccine

University Hospitals

Vaccine Recipient Information:

First Name_____ Last Name _____Date of Birth _____

Address_____ City_____State _____ Zip _____

Cell Phone _____

Do you have any other health conditions (including COVID-19)?

_____

Consent For Services: I have been provided with the Vaccine Fact Sheet corresponding to the vaccine(s) that I am receiving (Pfizer-BioNTech or Moderna or Johnson & Johnson (Janssen)). I have read or have had explained to me the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any adverse events that may result. I hereby release University Hospitals Health System, Inc. and its affiliates and subsidiaries, together with their officers, directors, employees, and agents (UH) from any liability which could result from this vaccination. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. By signing below, I, as or on behalf of the Patient, consent to receive and authorize UH to provide the services.

I request that payment of authorized benefits be made on my behalf to UH and assign the benefits payable to UH. I authorize UH to pursue payment for services and appeal the denial of payment for services on my behalf. I understand that UH may disclose my health information as set forth in the UH Notice of Privacy Practices, or as necessary for payment or to report to county, state, and/or federal agency. I authorize UH to contact me for any purpose by any means I have provided. I acknowledge that these communications or messages may contain protected health information. I consent to receive text messages, calls to my cell phone if provided, and/or communications using computer-aided technologies from UH (Optional Communication Methods). I may revoke consent to Optional Communication Methods at any time as set forth in the UH Notice of Privacy Practices.

For UH Employees: If applicable, I acknowledge and authorize that my vaccination status may be shared with UH, as my employer, until my employment with UH ends.

Authorization: I certify that to the best of my knowledge and belief the information provided, including for scheduling prioritization, is complete and correct. I understand that this consent is subject to revocation by me at any time except to the extent UH has already acted in reliance on this form. I UNDERSTAND THAT CHANGES OR ALTERATIONS TO THIS FORM ARE NOT BINDING ON UH AND REFUSAL TO SIGN MEANS I MAY NOT RECEIVE SERVICES.

For Minors: If the vaccine recipient is under 18, please ensure that a parent or guardian reviews this form and signs below. If a parent or guardian does not accompany a vaccine recipient under 18 to their appointment, the vaccine recipient must have the form signed and bring it with them in order to receive the vaccine.

Signature _____

If filling form out electronically, please print and sign signature field using a pen.

Full Name _____ Date_____

For authorized representative, description of relationship_____

Staff Use Only:

Screening Questions:

- ☐ Do you have any allergies?
- ☐ Do you have a fever?
- ☐ Do you have a bleeding disorder or use blood thinners?
- ☐ Are you immunocompromised or are on a medicine that affects your immune system?
- ☐ Are you pregnant or plan to become pregnant?
- ☐ Are you breastfeeding?
- ☐ Have you received another COVID-19 vaccine?
- ☐ Have you had a severe allergic reaction after a previous dose of this vaccine?
- ☐ Have you had a severe allergic reaction to any ingredient of this vaccine?

Vaccine Administration Information:

Administration Date _____/_____/_____ Vaccine Manufacturer _____

Lot # _____Exp. Date _____ / _____/_____ Site_____ Volume (mL) _____ Dose_____