COVID-19 VACCINE INFORMED CONSENT

_____ _____

Name Date of Birth

Covid-19 is the disease/illness that is caused by the introduction of the SARS-CoV-2 coronavirus into the human body. This virus spreads very easily from person to person, mainly through respiratory droplets produced when an infected person talks, sings, coughs or sneezes. These very small droplets can land in the mouths, noses and/or eyes of persons standing close by as well as within 6-12 feet of the infected person. It can also be transmitted by touching a contaminated surface then touching your face, eyes, nose, ears or mouth.

CLINICAL SYMPTOMS

The major symptoms of COVID-19 illness are fever, dry mouth, trouble breathing, shortness of breath, congestion new loss of taste or smell, chest pain, sore throat, runny nose, general body and muscle aches, headache repeated shaking with chills and confusion. You can also experience flu-like symptoms such as vomiting, nausea and diarrhea. The incubation period is generally 2-14 days but can be as long as 21 days after exposure to the virus or someone who is sick. Usually, symptoms appear within 5-11 days. A person does not have to be sick or have symptoms to transmit the virus to other people.

WHO SHOULD NOT RECEIVE THE COVID-19 VACCINE OR SHOULD WAIT

It is not currently recommended for these individuals to get the COVID-19 vaccine:

- Current fever or currently ill
- Severe allergic reaction (e.g., anaphylaxis) after a previous dose of a COVID-19 vaccine or any of its components.
- Severe allergic reaction to any ingredient of this vaccine
- Pregnant, those planning to become pregnant or lactating females should seek the advice of their physician before receiving the vaccine.

If in doubt or you have questions, please consult your physician.

CLINICAL SIDE EFFECTS OF COVID-19 VACCINE

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. However, the risk of a vaccine causing serious harm or death is extremely small. No serious problems have been identified with this COVID-19 vaccine to date.

Some mild problems include:

- Pain, redness, tenderness or swelling at the site of the injection or the lymph nodes on the arm where the vaccine was injected.
- Fever, fatigue, headache, nausea, joint pain, muscle aches and chills

These symptoms occur within the first three (3) days of vaccination and resolve within 1-3 days of onset.

The person receiving the vaccine will be observed for 15 to 30 minutes following the injection to monitor for potential severe reaction(s).

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VACCINE INFORMATION (FACT SHEETS) PROVIDED TO RESIDENT/CLIENT

- **Pfizer-BioNTech Vaccine: Fact Sheet Available at:**
  https://www.fda.gov/media/167212/download?attachment
- **Moderna Vaccine: Fact Sheet Available at:**
  https://www.fda.gov/media/167209/download?attachment
- **Novavax Vaccine: Fact Sheet Available at:**
  https://novavax.widen.net/s/w8gjmhb7s9/us-eua-fact-sheet-hcp

VACCINE ACCEPTANCE

☐ I have received the information for the COVID-19 vaccine identified above and I have been educated on the benefits and risks associated with the selected COVID-19 vaccine. I hereby given permission and request that this vaccine be administered to me or the person named for whom I am authorized to sign.

_____ _____
Patient/Resident/Representative Signature Date Signed

_____ _____
Witness Signature/Title Date Signed

REASON FOR VACCINE DECLINE (Medical or Personal Reasons)

☐ I have received the information for the COVID-19 vaccines and have been educated on the benefits and risks associated with these vaccines. I hereby **DECLINE** to receive any COVID-19 vaccine for the following reasons:

A. Medical Contraindication(s): Check all that apply
(Inform physician of medical condition)

- ☐ Previous history of severe reaction to vaccine
- ☐ Febrile illness at this time (Temp 101.5°F or 38.6°C)
- ☐ Other personal reason(s)
  Specify: _____

B. Personal Reason(s): Check all that apply
(Inform physician of personal reasons)

- ☐ Perceived vaccine ineffectiveness
- ☐ Fear of needles/injections
- ☐ Fear of side effects
- ☐ Other personal reason(s)
  Specify: _____

_____ _____
Patient/Resident/Representative Signature Date Signed

_____ _____
Witness Signature/Title Date Signed