**COVID-19 VACCINE CONSENT FORM**

Date:

Name:

Date of Birth:

I declare that I am 16 years of age or older. I further declare that I

1. Have not experienced anaphylaxis (difficulty breathing) or severe allergic reactions from a previous vaccination or an injectable medication.
2. Am not currently sick with a fever, active respiratory infection or other moderate/severe illness.
3. Have not had any other vaccinations in the previous days (e.g. MMR, Shingrix, Varicella, or a TB skin test).
4. Have not received anti-COVID monoclonal antibodies or convalescent plasma for treatment of COVID-19 within the past 90 days.
5. Have not been diagnosed with COVID-19 within the past 90 days.
6. Am not allergic to the ingredients in the COVID-19 vaccine.

I understand that the COVID-19 vaccine is a two-part vaccine series. I hereby agree that I will receive the first and second doses of the vaccine series.

I understand that the common risks associated with the vaccine include but are not limited to pain, redness or swelling at the injection site, headache, fatigue, muscle pain, chills, joint pain, fever, nausea, swollen lymph nodes. I understand that the vaccine may cause a severe allergic reaction which can include difficulty breathing, swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness. I understand that these may not be all the side effects of the COVID-19 vaccine. I also understand that it is not possible to know all possible side effects or complications which could be associated with the vaccine. I understand that the long-term side effects or complications of this vaccine are not known at this time.

I have received and read the FDA EUA Fact Sheet regarding COVID-19 vaccine. I understand and agree that the facility is required to submit COVID-19 vaccination administration data to the California Immunization Registry (CAIR2) and report moderate and severe adverse reactions following the vaccination to the Vaccine Adverse Event Reporting System (VAERS).

I understand and agree to all of the above and hereby give my consent to receive the COVID-19 vaccine.

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Printed Name Signature

Verbal consent obtained from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Resident representative if other than resident. Must be a surrogate decision maker if resident does not have the capacity to make decision).

Facility Representative:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_