COVID-19 mRNA Vaccine Consent

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

Last Name: ________________________ First Name: ________________________

Date of Birth: ________________________ Lawson Number: _____________________
(applicable only for Mercy co-workers)

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. currently have an 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 5 or older are eligible to receive the Pfizer COVID-19 vaccine. Individuals who are age 5-17 require parental/guardian consent to receive the **Pfizer COVID-19 vaccine**.* • *Individuals under the age of 18 are <u>Not</u> eligible to receive the **Moderna COVID-19 vaccine.*** 1. Are you 5 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. Are you pregnant or breastfeeding? Covid-19 vaccination is strongly recommended by the Centers for Disease Control and Prevention (CDC), options should be discussed with your healthcare provider.	*Yes* *N/A*	*No*
4. If receiving a third dose of a COVID-19 vaccine I attest that I am adhering to the time interval recommended by the manufacturer and the FDA (Food and Drug Administration); and that I am eligible for vaccination because:		
a. I am 12 or over and diagnosed with conditions or taking medications that are considered to have an equivalent level of immunocompromise to solid organ transplantation	*Yes*	*No*
b. I am age 18 or older	*Yes*	*No*

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

5. Have you ever received a dose of COVID-19 vaccine?	*Yes*	*No*
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 ever had a serious reaction to a vaccine or any other injectable therapy?	*Yes*	*No*
8. 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*
9a. Have you had COVID in the past 90 days and received antibody treatment?	*Yes*	*No*
9b. Have you had COVID in the past 90 days and diagnosed with multisystem inflammatory syndrome?	*Yes*	*No*

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 is being administered per guidelines issued by the FDA. I hereby certify that I have received and have read the "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 vaccine, dosed separated by 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 or as per the FDA/Manufacturers recommendations). 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. 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 Mercy to state immunization registries and other governmental authorities as required by law or by procedures related to COVID-19 vaccine distribution and administration tracking.

For Mercy Co-Workers: I understand that the COVID-19 vaccine is being administered to me as part of Mercy's Co-Worker Health program and agree that my COVID-19 vaccine administration record will be maintained by Mercy as part of my Co-Worker Health record.

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

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

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

Question #	Feedback
1. Are you 5 years or older? Those who are 5 to 17 years old will need parental consent.	If no, will not be able to receive vaccine today. Individuals who are 5-17 years of age are eligible for Pfizer COVID-19 vaccine but require parental/guardian consent to receive the Pfizer COVID-19 vaccine. Individuals under the age of 18 are NOT eligible for Moderna COVID-19 vaccine.
2. Are you feeling well today, and do you have a bodily temperature below (100°F)?	If Yes – allow to schedule If No – "Defer vaccination until improvement in symptoms for 24 hours"; do not allow to receive vaccine today.
3. Are you pregnant or breastfeeding? Covid-19 vaccination is strongly recommended by the CDC, options should be discussed with your healthcare provider.	If Yes, allow to schedule and vaccinate. Recipients should be encouraged to discuss with their healthcare provider. CDC recommendations: • Pregnant and recently pregnant people are more likely to get severely ill with COVID-19 compared with non-pregnant people. • Getting a COVID-19 vaccine can help protect you from severe illness from COVID-19. • COVID-19 vaccination is recommended for people who are pregnant, breastfeeding, trying to get pregnant now, or might become pregnant in the future. • Pregnant people may receive a COVID-19 vaccine booster shot. • Evidence about the safety and effectiveness of COVID-19 vaccination during pregnancy has been growing. These data suggest that the benefits of receiving a COVID-19 vaccine outweigh any known or potential risks of vaccination during pregnancy. • There is currently no evidence that any vaccines, including COVID-19 vaccines, cause fertility problems in women or men.
4. If receiving a third dose of a COVID-19 vaccine, I attest that I am eligible for vaccination for this event because:	• Active treatment for solid tumor and hematologic malignancies • Receipt of solid-organ transplant and taking immunosuppressive therapy • Receipt of CAR-T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy) • Moderate or severe primary immunodeficiency (e.g., DiGeorge, Wiskott-Aldrich syndromes) • Advanced or untreated HIV infection • Active treatment with high-dose corticosteroids (i.e., ≥20mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive,

	TNF blockers, and other biologic agents that are immunosuppressive or immunomodulatory • 18 or older
5. Have you ever received a dose of COVID-19 vaccine?	If Yes –For mRNA vaccines clarify which manufacturer's vaccine was given to assure administering the same vaccine for the second dose and for the third dose for immunocompromised patients. Booster doses (including booster dose for those that have received a single Janssen Vaccine) do not need to be from the same manufacturer.
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	If Yes, allergic reactions to components of the vaccine (polyethylene glycol PEG) are contraindications for receiving an mRNA vaccine. Do not allow to receive vaccine.
7. Have you ever had a serious reaction to a vaccine or any other injectable therapy in the past?	If Yes – "You will be required to be monitored for additional time (30 minutes). If a COVID vaccination is given, discuss with vaccinator when you arrive"; allow to schedule. If No – allow to receive vaccine today.
8. Have you had an immediate allergic reaction of any severity * after a previous dose of mRNA Covid-19 vaccine? *Immediate allergic reaction including anaphylaxis that occurs within four hours following administration. Signs and symptoms: Most occur within 15-30 minutes of vaccination. • Skin: pruritus, urticaria (hives), flushing, angioedema (e.g. swollen face, lips, tongue) • Respiratory: shortness of breath, wheezing, bronchospasm, stridor • Neurologic: confusion, disorientation, weakness, loss of consciousness • Cardiovascular: hypotension, tachycardia • GI: nausea, abdominal pain, vomiting	If Yes – "These reactions are a contraindication for receiving the vaccine. You will not be able to schedule an appointment at this time. You will need to discuss with your healthcare provider and obtain written approval to schedule and receive another dose of a mRNA COVID-19 vaccine". If No-allow to receive vaccine. NOTE: General expected reactions post vaccination that are not considered allergic reactions- allow to receive vaccine. • pain, redness, swelling, or soreness at injection site that is not immediate • lymphadenopathy in same arm as vaccination • fatigue • body aches • fever, chills • headache
8 a. Have you had COVID in the past 90 days and received antibody treatment?	If Yes – "Defer your vaccination until 90 days after antibody treatment; don't allow to schedule. If No – allow to receive vaccine today.
8 b. Have you had COVID in the past 90 days and diagnosed with multisystem inflammatory syndrome?	If Yes – "Defer your vaccination until 90 days from date diagnosed with multisystem inflammatory syndrome"; don't allow to schedule. If No – allow to receive vaccine today.