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 12 or older are eligible to receive the Pfizer COVID-19 vaccine. Individuals who are age 12-17 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 12 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* *N/A*	*No*

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* 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*
6. Have you received any other vaccines within the past 14 days?	*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*
9. In the past 90 days, have you received antibody treatment for COVID-19?	*Yes*	*No*

<u>COVID-19 – Survey Verification and Consent to Receive Vaccination</u>

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, doses 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). 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.

_____ _____

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 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.

_____

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

Question #	Feedback
1. Are you 12 years or older? Those who are 12 to 17 years old will need parental consent.	If no, will not be able to receive vaccine today. Individuals who are 12-17 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. If you are pregnant or breastfeeding, have you discussed the COVID-19 vaccine with your provider?	If Yes or If N/A – allow to schedule, allow to receive vaccine. No – "Discuss with your health care provider prior to presenting for vaccination"; allow to schedule; vaccinator to assure discussion occurs with provider before giving vaccine. If no, defer.
4. Have you ever received a dose of COVID-19 vaccine?	If Yes – clarify which manufacturer's vaccine was given to assure administering the same vaccine for the second dose.
5. 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.
6. Have you received any vaccines within the past 14 days?	If Yes – "Please defer your vaccination until 14 days after your last vaccine administration"; don't allow to schedule. If No – allow to receive vaccine today.
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 <u>immediate allergic reaction of any severity *</u> 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
9. In the past 90 days, have received antibody treated for COVID-19?	If Yes – "Please defer your vaccination until 90 days after your plasma or antibody treatment"; don't allow to schedule. If No – allow to receive vaccine today.