Wild Health, Clinic, 535 Wellington Way, Lexington, KY, Fayette County

Informed Consent Form for SARS-CoV-2 (Covid-19) Immunization

Who is receiving the vaccine? (Please print)

_____ _____ ____ Gender: ◯ M ◯ F

Last Name First Name Middle Name Date of Birth (MM/DD/YYYY) Age

_____ _____ _____ _____ (____) ____-____

Home Address City State Zip Phone Number

_____ _____ (____) ____-____

Emergency Contact Name Relationship to Patient Phone Number

Do you have a Primary Care Provider? ◯Yes ◯No _____ (____) ____-____

Primary Care Provider Name Primary Care Phone

	Screening Questions: Please answer each question by marking either "yes" or "no". If you answer "yes" to any question please discuss your answer with a health care provider.	**Yes**	**No**
1	Are you feeling sick today?		
2	Have you ever received a dose of COVID-19 vaccine? If yes, which vaccine product? ◯ Pfizer ◯ Jansen		
3	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?		
	• Was the severe allergic reaction after receiving a COVID-19 vaccine?		
	• Was the severe allergic reaction after receiving another vaccine or another injectable medication?		
4	Do you have a bleeding disorder or are you taking a blood thinner?		
5	Have you received passive antibody therapy as treatment for COVID-19?		

Informed Consent, Release, and Waiver: Please read and sign.

By my signature below, I consent to the administration of the vaccine for SARS-CoV-2, the virus that causes the Coronavirus Disease 2019 (Covid-19). I consent to be contacted at the number provided above regarding any required second dose of this vaccine that I may be due to receive. I understand, affirm, and acknowledge that:

1) I am of legal age and authorized to execute this consent form.
2) I have the option to accept or refuse the Covid-19 vaccine and I voluntarily consent to receive the vaccine.
3) The vaccine I am receiving is subject to Emergency Use Authorization (EUA) by the U.S. Food and Drug Administration (FDA), which permits the vaccine to be administered for emergency use when there are no adequate, approved, and available alternatives.
4) I have received, read, or have had read to me, the EUA *Fact Sheet for Recipients and Caregivers* provided for the vaccine to be administered and understand the benefits and risks of the vaccine to the extent such benefits and risks are currently known.

Have you completed all information on the other side of this document?

5) In addition to my answers to the questions on this form, I will immediately alert the health care provider before receiving the vaccine of any medical conditions which may adversely affect my personal health or the effectiveness of the vaccine.
6) I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I have also been counseled that there may be side effects or risks to the vaccine that are not identified in the *Fact Sheet for Recipients and Caregivers* and therefore cannot be reasonably known to the health care provider. I understand that I am responsible for following up with my primary care provider or other appropriate health care provider of my choice if I experience any side effects.
7) I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.
8) I have been advised that I should remain in the area for 15 minutes after the vaccination for observation.
9) If the vaccine recipient is a minor or an adult that is incapable of giving consent, I acknowledge by signing below that I am a parent or guardian with legal authority to execute this consent form on behalf of the minor receiving the vaccine and that all responses to the screening questions pertain to the minor on whose behalf I am acting.
10) This vaccination may be subject to reporting to federal and state health oversight agencies and to my primary care provider, if applicable, and I authorize these disclosures.
11) **Release and Waiver**: I fully release and discharge the health care provider, its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, relating to, or arising from, my receipt of the vaccine and I knowingly and voluntarily waive any and all claims or causes of action I may have against them related to, or arising from, my receipt of the vaccine.

Signature of Patient or Parent/Guardian of Minor: _____ Date: _____ Phone: _____

FOR HEALTH CARE PROVIDER USE ONLY

To be completed <u>BEFORE</u> administering the vaccine:

1) I confirmed the patient's name, D/O/B, and age to match information on the form. Initial here: _____
2) I reviewed the Screening Questions with the patient. Initial here: _____
3) I have given and discussed the *Fact Sheet for Recipients and Caregivers*. Initial here: _____
4) This is the patient's **First Dose** ◯ **Second Dose** ◯ of the Covid-19 vaccine. Initial here: _____
5) **If this is the patient's Second Dose**, I have confirmed:
   a) The patient's First Dose and Second Dose are of the same Covid-19 vaccine. Initial here: _____
   b) The patient's First Dose was given on _____ (MM/DD/YYYY). Initial here: _____

To be completed <u>AFTER</u> administering the vaccine:

Medication:_____ Mfr: _____ Lot #:_____ Exp. Date: _____ Site: ____ Laterality ____

Administered by: _____ Title: _____ Date Given:_____

Have you completed all information on the other side of this document?