Please fill this form out completely. We are unable to administer the vaccine until all the information required is provided and consents are read and signed. Thank you for your cooperation.

Patient Name:_____Date:_____COVID-19 Vaccination Consent

1. Are you feeling sick today? ☐ **Yes** ☐ **No**
2. Have you had a previous dose of COVID vaccine? _____ ☐ **Yes** ☐ **No**
3. Have you had a severe allergic reaction (e.g., needed epinephrine or hospital care) to a previous dose of this vaccine or to any of the ingredients of this vaccine? ☐ **Yes** ☐ **No**
5. Have you had any COVID-19 Antibody therapy within the last 90 days (e.g., Regeneron, Bamlanivimab, Convalescent Plasma, etc.)? ☐ **Yes** ☐ **No**
6. Have you had anaphylaxis or a severe allergic reaction to another vaccine or injectable medication? ☐ **Yes** ☐ **No**

Check all that apply to you:

- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (i.e., HIV infection, cancer)
- ☐ Take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of herparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 12 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to HAPPI Health (HAPPI) or its agents to administer the COVID-19 vaccine.

• I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.

• I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.

• On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless HAPPI Health, and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors, and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.

• I acknowledge that: (a) I understand the purposes/benefits of ImmPRINT Alabama's immunization registry will include my personal immunization information in ImmPRINT and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.

• I further authorize HAPPI or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to HAPPI or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if HAPPI invoices me after the time of service, upon receipt of such invoice.

• I acknowledge receipt of the Notice of Privacy Rights

Signature of Patient or Representative

_____

Provider/ RN sig: