# COVID-19 VACCINE CONSENT FORM

Patient Name: _____ DOB: _____ Age: _____

Account #: _____ (for CopperView Medical Center only)

Allergies: _____

Is this your 1st or 2nd dose of COVID-19 vaccine. Please circle one

1st

2nd

**If this is your 2nd dose you MUST bring your COVID-19 VACCINATION CARD with you**

**I declare that I or my child is 18 years of age or older. I further declare that I or my child:**

1. Have not experienced anaphylaxis (difficulty breathing) or severe allergic reactions from a previous vaccination or an injectable medication.
2. Have not had any other vaccinations in the previous 14 days (e.g. MMR, Shingrix, Varicella, or a TB skin test).
3. Is not currently sick with a fever, active respiratory infection or other moderate/severe illness.
4. Has have not received monoclonal antibodies or convalescent plasma for treatment of COVID-19 within the past ninety (90) days.
5. Is not allergic to the following ingredients in the MODERNA COVID-19 vaccine: messenger ribonucleic acid (mRNA), lipids (SM-102, polyethylene glycol [PEG] 2000 dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate trihydrate, and sucrose

**I understand that if I or my child have any of the above conditions, I or my child could be at increased risk of having a negative reaction or problem from the vaccine.**
**I further declare that if I or my child have any of the following conditions, I have had the opportunity to speak with my or my child's primary care provider and I am making an informed decision to receive the vaccine or to have my child receive the vaccine:**

1. Pregnant, attempting to become pregnant or breastfeeding;
2. Have a bleeding disorder or are on a blood thinner;
3. Are immunocompromised or are taking a medication that affects the immune system (such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease or psoriasis; HIV/AIDS, cancer, leukemia, ankylosing spondylitis or radiation treatments).

I understand that the COVID-19 vaccine is a two-part vaccine series. By signing this consent, I am agreeing that I or my child will receive the first and second part of the vaccine series.

I understand that the common risks associated with the COVID-19 vaccine include but are not limited to pain, redness or swelling at the site of injection, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, feeling unwell or swollen lymph nodes (lymphadenopathy). I understand that the vaccine may cause a severe allergic reaction which can include anaphylaxis (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 as the vaccine is still being studied in clinical trials. I also understand that it is not possible to predict 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 understand that the vaccination is being given by CopperView Medical Center. The owner and/or operator of this site, their affiliates, officers, directors, employees and agents expressly disclaim any responsibility for the vaccination. My consent is given in light of this knowledge, and in consideration of CopperView Medical Center giving the COVID-19 vaccine. I, for myself and my heirs, administrators, trustees, executors, assigns and successors in interest do hereby agree to release and hold harmless CopperView Medical Center, its subsidiaries, divisions, affiliates, successors, assigns, officers, trustees, employees, volunteers and agents from and against any and all demands, damages, losses, costs, expenses, obligations, liabilities, claims, actions and cause of action (whether any of which is groundless or otherwise) of any nature whatsoever (including, without limitation, reasonable attorney's fees and court costs) by reason of or resulting, in any way, from any and all acts, accidents, events, occurrences, omissions and the like related to, or arising out of, directly or indirectly, my receipt of this COVID-19 vaccine. CopperView Medical Center makes no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness for a particular purpose regarding the vaccine or its effectiveness.

Medicare Part B Recipients: I understand CopperView Medical Center will process Medicare Part B claims on my behalf and accepts Medicare payment in full. I understand I must present my Medicare card prior to receiving the vaccine. I understand that if I have assigned my Medicare benefits to a Medicare Advantage Plan (like an HMO or PPO), I must receive my COVID-19 vaccine shot from my HMO/managed care provider or pay the CopperView Medical Center charge.

Private Insurance Participants: If I have private insurance, I understand that CopperView Medical Center will bill my health insurance for the vaccine administration fee.

Self-pay Participants: If I have no insurance, CopperView Medical Center will ask for my information and bill the federal government's COVID-19 Uninsured Program

I understand and agree that CopperView Medical Center is required to submit COVID-19 vaccine administration data to the Utah Immunization Information System (UIIS), and report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS).

I understand and agree to all of the above and I hereby give my consent to the staff of CopperView Medical Center to give me or my child a COVID-19 vaccine.

_____

Patient Name

_____

Patient or Guardian Signature

_____

Date

COPPERVIEW ADULT CARE

# CopperView Medical Center

CopperView Pediatrics

## FOR VACCINE RECEIPIENTS:

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer 'yes' to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask the healthcare personnel to explain it.

| | NO | YES | NOT SURE |
|---|---|---|---|
| **1.** Are you feeling sick today? | | | |
| **2.** Have you ever received a dose of COVID-19 vaccine? | | | |
| • If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product _____ | | | |
| **3.** Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) | | | |
| • A component of a COVID-19 vaccine including either of the following: | | | |
| ○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures | | | |
| ○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids. | | | |
| • A previous dose of COVID-19 vaccine. | | | |
| • A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction. | | | |
| **4.** Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) | | | |
| **5.** Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies. | | | |
| **6.** Have you received any vaccine in the last 14 days? | | | |
| **7.** Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? | | | |
| **8.** Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? | | | |
| **9.** Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? | | | |
| **10.** Do you have a bleeding disorder or are you taking a blood thinner? | | | |
| **11.** Are you pregnant or breastfeeding? | | | |
| **12.** Do you have dermal fillers? | | | |

**Form reviewed by** _____ **Date** _____