Covid-19 Vaccine Informed Consent

NAME OF RESIDENT: ________________________________ **ROOM #**___________

ADMIT DATE: ______________________

ALLERGIES:

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SPECIFIC TYPE OF COVID-19 VACCINE:___**MODERNA**________

GENERAL INFORMATION: The Food and Drug Administration (FDA) gave Emergency Use Authorization on the use of Covid19 Vaccines. COVID-19 vaccines require two separate doses given about three or four weeks apart. Participants of clinical trials have reported experiencing short-term side effects after being vaccinated, with more pronounced discomfort after the second dose.

The common side effects of COVID-19 Vaccine include: Headache, Muscle pain & Joint pain, Fatigue, Chills & Fever, Pain at injection site, Cough and possible severe Anaphylactic reaction such: skin rash/hives, nausea/ vomiting, SOB, chest pain, tachycardia, hypotension, tongue swelling, lightheadedness.

Facility Staff will conduct covid-19 Vaccine screening prior to administration of the vaccine to ensure the resident meets criteria to receive the vaccine.

The Vaccine Information Statement(s) is/are provided to you outlining the risks and benefits of the vaccine(s)being offered. We request that you read the information provided and ask your Director of Nursing or responsible nurse if you have any questions.

To assure our ability to provide you or your loved one with the desired vaccinations(s), it is required that we retain a signed acknowledgement and Informed Consent (provided further below).

To be filled out by the immunizer: Patient Temperature: __________ Date: __________

(If patient answers yes to any of these questions or patient's bodily temperature is 100˚F or greater, please inform them that they should not receive the vaccine at this time, instruct them to contact their primary care provider for next steps and that the facility coordinator will be notified)

CONSENT FOR SERVICES: I have been provided or can request the Vaccine Information Sheet(s) corresponding to the vaccine(s) that the individual listed above will receive. I have read the information provided about the vaccine they are about to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I understand the individual stated above should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions. I understand if they experience side effects that I should do the following: call pharmacy, contact doctor, call 911. I request that the vaccine be given to the individual named above for whom I am authorized to make this request.

DISCLOSURE OF RECORDS: I understand that this facility or the pharmacy providing the vaccine may be required to or may voluntarily disclose health information regarding the vaccine administration for this resident to state or federal agencies as required by law, insurance companies as necessary, and any other person with a right to the vaccine administration information.

Signature of Resident if Own Responsible Party: ____

Date signed:____________________

If you are legally responsible for the resident listed above, please provide the following:

Name of Responsible Party or Power of Attorney:____

Relationship: ___________________________________ Date: _______________

Signature of Responsible Party or Power of Attorney: ____

Written Name: ____

Phone Number: ____