Beebe Healthcare

Covid-19 Vaccination & Administration Form

Name:		Date of Birth:
Address:		
Gender:	Race/Ethnicity:	Phone Number:
If you are insured, please list name of provider:	Plan Name: _____ Group ID: _____	Member ID: _____

I have discussed any concerns regarding the COVID-19 Vaccine and any medical conditions I may have with my Healthcare Provider. I have either been advised by my Provider that I may proceed with the COVID-19 Vaccine OR, if my Provider has advised against receiving the COVID-19 Vaccine, I have taken the discussion into consideration and have decided to proceed with the COVID-19 Vaccine based on my own personal decision.

You must initial ALL statements if you are to receive the COVID-19 vaccination:	Initials
I have never had an allergic or anaphylactic reaction to a COVID-19 vaccine or polyethylene glycol (Pfizer, Moderna) or polysorbate (Johnson & Johnson/Janssen).	
• I do not have known, active COVID-19 infection • In the past 90 days, I have not received monoclonal antibodies for COVID-19	

I understand that Emergency Use Authorization (EUA) is a pathway to make unapproved medical products available during public health emergencies.

Vaccine you are receiving today (Box to be checked by Beebe Staff Member)		Full FDA Approval Granted	Approved under FDA EUA (Emergency Use Authorization)	Risks
Pfizer BioNTech ages 16 and older	☐	YES	N/A	See separate Vaccine Information Fact Sheet provided (used interchangeably for **all** Pfizer vaccines -- fully approved ages 16 and older as well as Emergency Use Authorization ages 12-15)
Pfizer BioNTech ages 12-15 **and** 3rd Dose ages 12 and older **and Booster Dose** ages 18 and older	☐	NO	YES	
Moderna ages 18 and older	☐	NO	YES	See separate Moderna Fact Sheet for Recipients and Caregivers Emergency Use Authorization (EUA) provided
Johnson Johnson/Janssen ages 18 and older	☐	NO	YES	See separate J&J Fact Sheet for Recipients and Caregivers Emergency Use Authorization (EUA) provided Please note specific risks of: **blood clots** and **low platelet levels** as well as **Guillain Barré syndrome** in Fact Sheet.

<u>Risks applicable to all of the above vaccines:</u>

- Injection site reactions: pain, tenderness, redness, swelling, where the shot is given can happen. Swelling of the lymph nodes. General Side Effects: fatigue, headache, muscle pain, joint pain, chills, nausea and vomiting, and fever.
- As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

I understand there are different brands of vaccine available and I am choosing to receive the brand offered today. I also know I have the option not to receive a Covid-19 vaccine.

I have read the separate CDC V-Safe℠ document provided to me and I agree to report side effects to my Provider and/or the CDC via V-Safe℠. In the event of a medical emergency, I understand that I should call 911 for immediate medical intervention.

My signature below verifies my initialed statements above, as well as agreement to release Beebe Healthcare and/or Beebe Medical Group and/or its employees from any and all claims arising out of the Covid-19 Vaccine I received.

If you are a resident of the State of Delaware, today's Covid-19 vaccination will be added to the Federal Immunization Registry and the Delaware State Immunization Registry so your Physician has access to that information.

_____   _____   _____   _____   _____   _____
Patient Signature   Date   Time   Signature of Healthcare Provider   Date   Time
                                                                                                                     Providing Consent Information

_____
Signature of Legal Representative of Patient (if patient unable to provide consent)

_____   _____   _____   _____
Printed Name of Legal Representative of Patient (if patient unable to provide consent)   Date   Time   Relationship to Patient

_____   _____   _____
Witness to Signature (different from person who provided consent info.)   Date   Time

_____   _____   _____
2nd Witness (needed if consent obtained via telephone/videoconference)   Date   Time

Certified Medical Interpretation:

I translated the wording in this form as well as any additional written information and interpreted verbal information provided to the patient or legal representative in the following language _____ and did so using the following method:

☐ In Person Interpreter. Interpreter Signature: _____
☐ Over the Phone Interpreter ("OPI"). Print interpreter name: _____ Identification Number: _____
☐ Instant Remote Interpreting Service ("**IRIS**"). Print interpreter name: _____ Identification Number: _____

DO NOT WRITE BELOW THIS LINE

Manufacturer:	DELTOID R L	Route: Intramuscular
NDC:		
Vaccine Lot:	Clinician Signature:	
Exp Date:	Date:	

Form #10679   1/19/21, 2/11/21, 5/8/21, 5/14/21, 7/14/21, 8/13/21, 9/24/21