

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 receivi	ng today	Full FDA	Approved under FDA	Risks
· · ·		Approval	EUA (Emergency Use	
(Box to be checked by Beebe Staff Member)		Granted	Authorization)	
Pfizer BioNTech ages 16 and older		YES	N/A	See separate Pfizer Fact Sheet for Recipients and Caregivers for those who are ages 12 years and older
Pfizer BioNTech ages 5- 15 and <u>3rd Dose</u> ages 12 and older and Booster Dose ages 16 and older		NO	YES	or See separate Pfizer Fact Sheet fo Recipients and Caregivers for those who are 5 through 11 years of age
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.



Risks applicable to all of the above vaccines:

- 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-SafeSM document provided to me and I agree to report side effects to my Provider and/or the CDC via V-SafeSM. 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 Providing Consent Information			Date	Time	
Signature of Legal Representative of Patient	t (if patient unable	to provide con	sent)					
Printed Name of Legal Representative of Pa	tient (if patient u	nable to provid	e consent)	Date	Time	Relatio	onship to Patien	t
Witness to Signature (different from person	who provided	consent inf	o.)	Date	Time	_		
	ne/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 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:				
	Date:				
Exp Date:					