BayCare Health System, Inc.

Consent Form for Administration of

COVID-19 Pfizer-BioNTech, Moderna or Janssen (J&J) Vaccine (the"Vaccine")

Patient Name: _____ Team Member # or Medical Staff (Cerner) #_____

Date of Birth: _____ Age: _____ Gender (circle one): Male / Female

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Vaccine Administration Location (circle one): BSO SJH WHH

Legal Guardian (if patient is under 18 years old): _____Telephone: _____

Emergency Contact: _____ Telephone: _____

Primary Physician: _____ Telephone: _____

Screening Questions: **Please Circle**

1.	Are you **less** than 18 years old?	Yes	No	
2.	Have you ever had an anaphylactic reaction to a vaccine or other injectable medication?	Yes	No	
3.	Do you have a fever or feel ill today?	Yes	No	
4.	*Have you previously received a COVID-19 vaccine?	Yes	No	
5.	Are you allergic to any component of the vaccine as listed in the FDA Fact sheet?	Yes	No	
6.	Have you received another vaccine (including influenza vaccine) in the last 2 weeks?	Yes	No	
7.	Have you received a COVID-19 monoclonal antibody infusion or convalescent plasma in the last 90 days?	Yes	No	
If you answered Yes to question 1-7, you are not eligible to receive the COVID-19 vaccine at this time. *Exception: If this is a required second dose, please present the vaccine card received from the 1st dose.				
8.	Are you pregnant or breast feeding?	Yes	No	
9.	If you have tested positive or have COVID-19 symptoms, has it been 10 or less days from onset of COVID-19 symptoms or a COVID-19 positive test?	Yes	No	NA
10.	Are you immunocompromised or taking medications that may compromise your immune system?	Yes	No	
If you answered Yes to question 8-10, you should consult your physician before receiving the COVID-19 vaccine.				

I hereby acknowledge the following:

_____ **I have provided full and accurate information for the completion of this Consent Form.**

_____ **I understand that my failure to provide full and accurate information regarding my health status may result in adverse health consequences to me.**

_____ **I understand that this vaccination program is not a substitute for my physician's recommendations, advice, or treatment, and if I have any concerns about receiving the Vaccine and/or any of my responses to the above questions, I should discuss with my physician before receiving the Vaccine.**

Revised: 3/4/2021

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_____ **I agree to stay in the general area for fifteen (15) minutes after receiving the Vaccine to ensure that no immediate reactions occur.**

_____ **I understand that if I experience any side effects from the Vaccine, it will be my responsibility to inform the on-site health care professional administering the Vaccine of those side effects and to follow up with my physician.**

_____ **I have received, read, and understand the contents of the attached Vaccine Information Sheet (VIS) or Emergency Use Authorization (EUA).**

_____ **I understand that:**

_____ **Known potential adverse reactions to the Vaccine include each of the potential adverse reactions identified in the VIS or EUA provided to me.**

_____ **There may be additional adverse reactions to the Vaccine that are not identified in the VIS or EUA provided to me.**

_____ **I have had the opportunity to ask questions concerning the Vaccine, the administration of the Vaccine, and potential adverse health consequences of receiving the Vaccine, and all of my questions have been answered to my satisfaction.**

_____ **I understand that I am not required to receive the Vaccine; however, I have voluntarily chosen to receive the Vaccine and accept all known and potential risks related to receiving the Vaccine.**

Consent and Waiver: I understand the benefits and risks of the Vaccine and I expressly consent, request, and authorize the administration of the Vaccine to me by representatives of BayCare Health System, Inc. I fully release and discharge BayCare Health System, Inc., its affiliates and their officers, directors, employees, and persons acting on their behalf or at their direction from any and all liability or claims related in any way to the administration, or my receipt, of the Vaccine.

Signature of patient or Legal Guardian: _____ Date: _____

To be completed by a BayCare Health System, Inc. representative:

Administered by: _____ Title: _____

Date Given: _____ Site: (circle one) Left Deltoid Right Deltoid

Please Check One and Validate Lot # and Expiration Date

☐ Medication: Pfizer-BioNTech COVID-19 Vaccine VIS/EUA Date: 2/25/2021 Lot #: EH9899 Exp Date: 03/2021

☐ Med**ication: Moderna COVID-19 Vaccine VIS/EUA Date: 12/18/2020**

☐ Med**ication: Janssen (J&J) COVID-19 Vaccine VIS/EUA Date: 2/27/2021**

Place Moderna
Lot# and Exp Date sticker here

Revised: 3/4/2021