COVID-19 VACCINE CONSENT FORM

Information about person to receive vaccine (please print)

Name: ______________________ **Birth date:** ___/___/_____ **Age:** _______ **Sex:** ☐ Male ☐ Female

Race: ☐ Asian ☐ Black ☐ Native American ☐ Pacific Islander ☐ White ☐ Other **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

Address: ______________________ **City:** ______________________ **State:** _____ **Zip:** _______

Phone: ______________________ **Do you have insurance?** ☐ No ☐ Yes

Please Complete the following:

Question	
Has the person to be vaccinated ever received a COVID-19 vaccine?	*Yes* ☐ *No* ☐
If yes, date: _______________ Type/Brand of COVID vaccine: _______________	
Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex?	*Yes* ☐ *No* ☐
List all allergies if applicable:	
Is the person to be vaccinated at least 18 years old	*Yes* ☐ *No* ☐
Has the person to be vaccinated ever had a severe reaction to any medication?	*Yes* ☐ *No* ☐
Is the person to be vaccinated sick today or running a fever greater than 100.4?	*Yes* ☐ *No* ☐
Are you pregnant, planning to get pregnant or breastfeeding?	*Yes* ☐ *No* ☐
Are you immunocompromised or are you on a medicine that affects your immune system?	*Yes* ☐ *No* ☐
Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner?	*Yes* ☐ *No* ☐
Has the person to be vaccinated received any other vaccines in the past 14 days?	*Yes* ☐ *No* ☐
Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19?	*Yes* ☐ *No* ☐

I hereby acknowledge receipt of a copy of the "Fact Sheet for Recipients and Caregivers" regarding the COVID-19 Vaccination. I further warrant and represent that I have read and understood the same. I understand and agree that the FDA has authorized the emergency use of Moderna COVID-19 Vaccine, although it is not a FDA-Approved vaccine, I understand the potential risks and benefits of Moderna Vaccine and the extent to which such risks and benefits are unknown. I also have been provided information regarding available alternative vaccines and risks and benefits of those alternatives. I understand that I, as the recipient (or I as the parent or guardian of the recipient, if applicable) have the option to accept or refuse this vaccine. It is not required to be taken. I understand that Seward County Health Department (SCHD) is required to submit COVID-19 vaccine administration data to the Kansas Immunization Information System (KSWebIZ), and report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS). I expressly consent to the distribution of such data to KSWebIZ and VAERS by SCHD. I also acknowledge that the release of certain data and information may otherwise be required by law.

I understand the vaccination is being given by the SCHD. SCHD, Seward County, its elected officials, agents, employees, successors, assigns and affiliates **expressly disclaim** any and all responsibility or liability for the Covid-19 vaccination, including but not limited to its administration, effectiveness, safety, or potential side effects. My consent is given in light of this knowledge and in consideration of SCHD giving the COVID-19 vaccine. I, for myself, my ward, my heirs, administrators, trustees, executors, assigns, and successors in interest do hereby agree to release, hold harmless, and indemnify, the Seward County Health Department, Seward county, its elected officials, 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 (or, if I am a parent or guardian, my child's or ward's) receipt of this COVID-19 vaccine. **Seward County and The Seward County Health Department make no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness for a particular purpose regarding the vaccine, its effectiveness, side effects, or safety.**

If I am consenting on behalf of another person, I hereby represent and warrant that I have full authority to do so.

I understand and agree to all of the above and I hereby give my consent to the staff of the Seward County Health Department to give me or the individual listed above a COVID-19 vaccine. I have read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 vaccine. I have had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of this COVID-19 vaccine. I therefore give consent that the first and second dose of the vaccine be given to me or the person named above for whom I am authorized to make this request (as a parent or guardian) by the Seward County Health Department. I hereby assume the risk of taking the vaccine (or having it administered to my child or ward).

I HAVE BEEN ADVISED AND AGREE TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY (or my child's or ward's) VACCINE BEFORE LEAVING.

I understand that the COVID-19 vaccine is a two-part vaccine series and is not considered fully administered until I receive two doses of vaccine which is given 28 days after the first dose. By signing this consent, I am agreeing and herby give my consent to Seward County Health Department administering the vaccine as well as to all of the above.

Print Parent/Guardian name, if different from patient: ______________________________
Patient/Parent/Guardian Signature: ______________________________ Date: ____________

FOR INTERNAL USE ONLY

Initial Dose Manufacturer:		Booster Dose:	
Date:		Date:	
Lot #:	Exp:	Lot #:	Exp:
Site:	Route:	Site:	Route:
Vaccine Administrator:		Vaccine Administrator:	
Nurse's Comments:		Nurse's Comments:	