BronxCare Health System

COVID-19 VACCINE
Consent Form 2020-2021

Name: ____

DOB: ___________________ **Gender:** __________________

Address: ____**City**________**State**_______**Zip**_________

Marital Status: ___________________ **(DECL – Declined; S – Single; D – Divorced; M – Married; W – Widowed; V – Civil Union; U – Unknown; SEPARATED – Legally Separated; PARTNER – Life Partner)**

Race: ___________________ **(AIA – Native American or Alaskan; ASN – Asian; BAA – African American or Black; DECL– Declined; NHP – Native Hawaiian or Pacific Islander; WHT – White OTH – Other or Multiracial)**

Ethnicity: ___________________ **(DECL – Declined HIS – Hispanic Origin ;NHL – Non-Hispanic Origin; UNK – Unknown)**

Contact No.: ___________________ **Email Address:**___________________

	Screening Questionnaire	**CIRCLE ONE**		
1	Are you feeling sick today?	Yes	No	
2	In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	Yes	No	Unknown
3	Have you been treated with antibody therapy for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?*	Yes	No	Unknown
4	Have you had any vaccines in the past 14 days (2 weeks) including flu shot? If yes, how long ago was your most recent vaccine?	Yes	No	Unknown
5	Are you pregnant or considering becoming pregnant?	Yes	No	Unknown
6	Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	Yes	No	Unknown
7	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	Yes	No	Unknown
8	Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot?	Yes	No	Unknown
9	Do you have a history of severe allergic reactions not related to vaccines or injectable medications — such as allergies to food, pet, venom, environmental, or latex? *If yes, I understand that I need to be monitored for 30 minutes on-site after getting the vaccine.*	Yes	No	Unknown

Note of Acknowledgement and Consent

I have read and understood the information on both sides of this form and have provided the above information voluntarily. All of my questions regarding this form, and the nature of the vaccine, its expected benefits, and its risks have been answered to my satisfaction and at this time:

□ **Consent to receive** the COVID-19 Vaccination
□ **Decline** the COVID-19 Vaccination.

Patient Signature: ______________________________________ **Date/Time** __________________

COVID-19 VACCINE

BronxCare Health System is offering voluntary vaccinations to prevent Coronavirus Disease ("COVID-19"). BronxCare advised me that there would be no adverse consequences to my employment if I chose not to receive this vaccination. Further, BronxCare did not seek to coerce or pressure me to sign this Consent and Release Form.

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product, and the duration of protection is still unknown. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Confidentiality/Privacy

I understand privacy laws prohibit BronxCare from disclosing my medical/health information obtained in connection with this vaccination without my permission except as may be required by law. BronxCare will keep any health or other confidential information received from me in connection with this COVID-19 Vaccine in separate medical files and will treat it as a confidential medical record.

I acknowledge that I am aware of the following facts:

- The vaccine is voluntary and I am not required to receive this vaccination as a condition of employment. - I have the option to accept or refuse the COVID-19 Vaccine.
- I have been given a copy and have reviewed the Fact Sheet for Recipients and Caregivers for the Emergency Use Authorization (EUA) of the COVID-19 Vaccine to Prevent Coronavirus Disease 2019 (COVID-19)
- I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective.
- The significant known and potential risks and benefits of the COVID-19 Vaccine, and the extent to which such risks and benefits are unknown.
- Information about available alternative vaccines and the risks and benefits of those alternatives.
- The vaccination provider may include my vaccination information in my state/local jurisdiction's Immunization Information System (IIS) or other designated system. This will ensure that I receive the same vaccine when I return for the second dose. For more information about IISs visit: https://www.cdc.gov/vaccines/programs/iis/about.html.
- Receiving the vaccination does not mean I am exempt from BronxCare's workplace safety protocols and quarantine policies and all applicable federal, state and/or local guidance on isolation and quarantine to avoid infecting others, which remain applicable.

I agree to contact my primary care provider if I have any concerns or an adverse reaction to the COVID-19 Vaccine. I will immediately contract 9-1-1 or go to the nearest hospital should I experience any of the following shortly after receiving the COVID-19 Vaccine: difficulty breathing, swelling of my face and throat, a fast heartbeat, a bad rash all over my body, dizziness and weakness, or other signs of a severe allergic reaction.

You may also report vaccine side effects to **FDA/CDC Vaccine Adverse Event Reporting System (VAERS)** toll-free number at 1-800-822-7967 or online to https://vaers.hhs.gov/reportevent.html.

AREA BELOW TO BE COMPLETED BY ADMINISTERING PROVIDER

Which vaccine is the patient receiving today?				
Vaccine Name and Dosage	**Administration**		**EUA Fact Sheet Date**	**Manufacturer & Lot No.**
Pfizer/ BioNTech (0.3 mL)	**□ 1st Dose**	**□ 2nd Dose**		
Moderna (0.5 mL)	**□ 1st Dose**	**□ 2nd Dose**		

Administration Site: □ Left Deltoid □ Right Deltoid

□ I have reviewed side effects with the patient receiving the vaccine today.

□ I confirm that the patient receiving the vaccine today was given an opportunity to ask questions about the vaccination, and all the questions asked by them have been answered correctly and to the best of my ability.

Did the recipient develop any adverse reaction(s) to the first dose: □ YES □ NO □ N/A
If Yes, please describe the adverse reaction: ______________________________

Vaccinator Name/Title: _____________________________________
Vaccinator Signature: _____________________________________
Date/Time: _____________________________________