**COVID-19 VACCINATION CONSENT FORM**

I voluntarily request that the Loyola University of Chicago Wellness Center (the “LUC WC”) give the Pfizer-BioNTech coronarvirus SARS-CoV-2 (a/k/a COVID-19) Vaccine (the “COVID-19 Vaccine”) to me or to the person named below for whom I am authorized to make this request (select one): **\_\_\_\_\_ MYSELF \_\_\_\_\_ OTHER PERSON**

**Recipient’s Information (“Recipient”):**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial:\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorized Individual’s Information (complete if different from COVID-19 Vaccine Recipient):**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial:\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge, understand and consent to the following:

1. I, as or on behalf of the Recipient, voluntarily consent to receive and authorize LUC WC to provide the COVID-19 Vaccine.
2. I understand the known and potential benefits and risks of and alternatives to the COVID-19 Vaccine, and the extent to which benefits and risks are unknown. I voluntarily assume all risks and full responsibility for any injury, loss, damage or other adverse events that may result from the vaccination. I hereby waive, indemnify, hold harmless, release and discharge Loyola University of Chicago (including the LUC WC), its affiliates and subsidiaries and their respective trustees, officers, employees, representatives, agents, contractors, volunteers, successors and assigns from any liability which could result from this vaccination.
3. I have had the opportunity to read Pfizer-CioNTech COVID-19 Vaccine EUI Recipient Fact Sheet, version 1/7/22.I have been given the opportunity to ask questions, which have been answered to my satisfaction.
4. I understand that the Recipient’s vaccination information will be added to the Recipient’s medical record and may be disclosed to appropriate applicable international, federal, state, and local governments, departments, agencies and public health authorities as may be required, permitted or otherwise allowed by law. Unless otherwise indicated below, I have consented to and opted-in to authorize, allow and permit LUC WC to share and disclose my COVID-19 Vaccine records with the State of Illinois through the Illinois Comprehensive Automated Immunization Registry Exchange (“I-CARE”).
5. The COVID-19 Vaccine may not protect all COVID-19 Vaccine recipients. Immunocompromised persons may have a diminished immune response to the COVID-19 Vaccine.
6. The Recipient will remain in the vaccination area at LUC WC until released and will report back to the nurse or pharmacist if the Recipient experiences any unusual effects before leaving the LUC WC.

**MEDICAL SCREENING QUESTIONS: Check yes or no to each question below for the Recipient.** Tell the LUC WC vaccination provider about all medical conditions, including if the answer is “yes” to any question. Except for the last two questions, a “yes” response to any other question means the Recipient may wish to consult with the Recipient’s healthcare provider before proceeding. Answering “yes” to either of the last two questions means the Recipient should not be vaccinated today.

|  |  |  |
| --- | --- | --- |
| **Question** | **Yes** | **No** |
| Do you have any allergies? |  |  |
| Do you have a fever? |  |  |
| Do you have a bleeding disorder or are on a blood thinner? |  |  |
| Are you immunocompromised or are you on a medicine that affects your immune system? |  |  |
| Are you pregnant or plan to become pregnant? |  |  |
| Are you breastfeeding? |  |  |
| Have you received another COVID-19 Vaccine? |  |  |
| If yes, what vaccine did you receive? |  | |
| Date of vaccine(s) | | |
| Have you had a severe allergic reaction after a previous dose of this COVID-19 Vaccine? |  |  |
| Have you had a severe allergic reaction to any ingredient of this COVID-19 Vaccine? |  |  |
| Do you consent and opt-in to authorize, allow and permit LUC WC to share and disclose your COVID-19 Vaccine records through I-CARE? |  |  |

**Signature of Recipient OR Authorized Individual for Recipient Date**

**DO NOT WRITE IN THIS SPACE-OFFICE USE ONLY VIS Edition Provided:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_**

# Vaccine: ­­\_\_ Manufacturer:

# Prior Vaccine Dose Administration Date(s): \_\_\_

Administration Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Lot#: \_

Exp. Date: \_ Site:-------------

# Route: \_

Volume **(ml): \_**

Provider’s Signature Date Time