Health Care District
PALM BEACH COUNTY

Informed Consent for COVID-19 Vaccination

Section A-1

Please print clearly

First Name: _____ **Last Name:** _____ **Date of Birth:** / / **Age:** _____

Gender: ☐ Female ☐ Male **Race:** ☐ Black or African American ☐ White ☐ Asian ☐ American Indian/Alaskan Native

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Native Hawaiian/Pacific Islander ☐ Other

Home Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Patient Email: _____ **Phone:** ( ) - **Healthcare Employer Name:** _____

PLEASE SELECT ONE BELOW:

1) ***Based on availability, I want to receive the following vaccination(s): Moderna mRNA cx-024414 COVID-19 Vaccination***

First dose ☐ Second dose ☐

2) ***Based on availability, I want to receive the following vaccination Pfizer–BioNTech mRNA BNT162b2 COVID-19 Vaccine***

First dose ☐ Second dose ☐ Third Dose ☐

3) ***Based on availability, I want to receive the following vaccination: Janssen (Johnson & Johnson) COV3001 COVID-19 Vaccination single dose vaccine***

Single dose ☐

Section A-2

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) a person authorized to consent on behalf of the patient where the patient is not otherwise competent or unable to consent for themselves. Further, I hereby give my consent to The Health Care District of Palm Beach County and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the EUA Fact Sheet on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised that the patient should remain near the vaccination location for observation for approximately 15 to 30 minutes after administration. On behalf of the patient, the patient's heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. (Initial below)

_____ **I acknowledge that if I receive a *Moderna mRNA cx-024414 COVID-19 Vaccination* or *Pfizer–BioNTech mRNA BNT162b2 COVID-19 Vaccine*, I will require a second dose of the vaccine 21-28 days later from the date of the first, for long-term protection.**

_____ **I give permission to the Health Care District of Palm Beach County to enter this vaccine into the Florida SHOTS database.**

I acknowledge that: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, or to any state or federal governmental agencies or authorities ("Government Agencies"), such as state, county, or local Departments of Health or the federal Department of Health and Human Services, the Center for Disease Control and Prevention, or their respective designees as may be required by law, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that I may authorize, by using a state-approved opt-in form or, as permitted by my state law, an opt-in form ("Opt-In Form") furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-In Form. However, unless I provide the applicable Provider with a signed Opt-In Form, I understand that my health information will not be shared with the State HIE, except as further explained below. If I provide the applicable Provider with a signed Opt-In Form, my consent will remain in effect until I withdraw my permission, which I may do at any time and for any reason, by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable.

I understand that even if I do not consent or if I withdraw my consent, my state's laws or federal law may permit certain disclosures of my vaccination information to or through the State HIE or to Government Agencies as required or permitted by law. I further authorize the applicable Provider to: (a) release my medical or other information, including any communicable disease (including HIV), and mental health information, to, or through, the State HIE or Government Agencies to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment; (b) submit a claim to my insurer for the above requested items and services; and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services.

Revised 10/6/2021

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Opt in: I do want my health information to be included in the HIE.
I have read and fully understand the above information provided to me regarding the Provider HIE and I am opting in.

Signature of Patient or Authorized Representative: _____

Date: ___/___/___

I acknowledge receipt of the Notice of Privacy Rights.

Signature of Patient or Authorized Representative: _____

Date: ___/___/___

Section B-1

Please print clearly

1. **Have you ever had a severe allergic reaction to a previous dose of COVID-19?** **If you answered yes to this question, you will not receive your vaccine today. Please contact your Primary Care Provider for further guidance.**	Yes ☐	No ☐	Don't Know ☐
2. **Have you ever had a severe allergic reaction [e.g., anaphylaxis] to something that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital? It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.** **If you answer yes to this question, you will need to wait for 30 minutes, instead of the standard 15 minutes, in the Observation area after you receive your vaccine.**	Yes ☐	No ☐	Don't Know ☐
3. **Do you feel sick today?**	Yes ☐	No ☐	Don't Know ☐
4. **Have you had COVID-19 in the last 90 days?**	Yes ☐	No ☐	Don't Know ☐
5. **Are you pregnant or considering becoming pregnant in the next month or breast feeding?**	Yes ☐	No ☐	Don't Know ☐
6. **Are you immunocompromised or on a medication that decreases your immune system?**	Yes ☐	No ☐	Don't Know ☐
7. **Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?**	Yes ☐	No ☐	Don't Know ☐
8. **Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?**	Yes ☐	No ☐	Don't Know ☐

If you answered "yes" to any of the above questions, please discuss with your Primary Care Provider (PCP) before proceeding with COVID-19 vaccination.

Females only 18-49 years of age receiving the *Janssen (Johnson & Johnson) COV3001 COVID-19 Vaccination*:

Have you received and reviewed the Emergency Use Authorization (EUA) for the *Janssen (Johnson & Johnson) COV3001 COVID-19 Vaccination*?
Yes ☐ No ☐

Section B-2

Please print clearly

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient or representative of; or (c) a representative of the Health Care District of Palm Beach County and, based upon clinical observation, have sufficient knowledge of the patient's condition to answer the Screening Questions. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

Signature of Patient or Authorized Representative: _____

Date: ___/___/___

Thank you!

Revised 10/6/2021