COVID-19 Vaccine Consent Form

Name of Individual to be Immunized:

This Vaccine Consent Form is to be used for the COVID-19 vaccination of any individual administered at a Community Mass Vaccination site.

I declare that I, or my child/vaccine recipient, is 16 years of age or older. I further declare that:

I understand that this vaccine has been made available for use under an Emergency Use Authorization ("EUA") process by the Food and Drug Administration (FDA). This EUA process was used to facilitate the timely development of this vaccine in addition to ensuring its quality, safety and effectiveness.

I understand the benefits of getting a COVID-19 Vaccine include:

- COVID-19 vaccination will help keep you from getting COVID-19
- COVID-19 vaccination may also protect the people around you
- COVID-19 vaccination helps build protection against COVID-19 coronavirus infection

I understand the common side effects of COVID-19 Vaccine include:

- Pain in/at the site of injection
- Muscle/joint ache
- Fatigue
- Headache
- Fever
- Chills

These symptoms may be more common after the second dose of the vaccine and usually resolve in 24 to 48 hours.

I understand there is a small chance I may not receive the protective benefits of this Vaccine.

- Although this vaccine has been shown to be highly effective, it has not been shown to prevent infection in 100% of the trial population who received the vaccine.
- I understand that if I am immunocompromised the effectiveness of the vaccine may be reduced.

I understand that there is a potential risk of a severe allergic reaction to the Vaccine

I understand that there is a small chance that the COVID-19 Vaccine could cause a severe allergic reaction particularly in people who have experienced an anaphylactic (severe allergic) reaction in the past. **If I (or my child/vaccine recipient) am receiving this vaccine and I (or my child/vaccine recipient) have a history of severe allergic reaction, I have been instructed to discuss the risks/benefits of this vaccine with my (or my child's/vaccine recipient's) healthcare provider prior to receiving the Vaccine.**

I understand there may be additional unknown risks to the COVID-19 Vaccine

I understand that the side effects listed above may not be all the side effects of the COVID-19 vaccine as the vaccine is still being studied in clinical trials. I understand that the long-term side effects or complications of this vaccine are not known at this time.

I understand that I (or my child/vaccine recipient) should not receive the COVID-19 Vaccine if I (or my child/vaccine recipient) am allergic to any of the ingredients of the COVID 19 vaccine or if I (or my child/vaccine recipient) has received any vaccines within the past 14 days.

UNIVERSITY of MARYLAND MEDICAL SYSTEM

UNIVERSITY OF MARYLAND MEDICAL CENTER

Consent for Treatment

DOB:

MRN:

Adm Date:

Acknowledgement:

1. **I have read or have had explained to me the Emergency Use Authorization Information/Fact Sheet ("EUA") concerning the COVID-19 vaccine I or my child/vaccine recipient am receiving and understand the information and recommendations contained therein.**
2. I understand that if I or my child/vaccine recipient am receiving a second dose of a two (2) dose COVID 19 vaccine, I will confirm with the vaccinator, at the time of my or my child/vaccine recipient second vaccination, the manufacturer of both vaccines is the same.
3. **CHILDREN 16 AND 17 YEARS OF AGE: I understand that if I am the parent or guardian of a child receiving a two (2) dose COVID 19 vaccine, my child may only receive the vaccine manufactured by Pfizer Pharmaceuticals. Prior to each vaccination, I will confirm with the vaccinator that the vaccine being administered to my child is the Pfizer COVID 19 vaccine.**
4. I understand that this site will submit this immunization information to the state immunization registry.

I understand the benefits and risks of the COVID-19 vaccine and request that it be given to me (or my child/vaccine recipient).

Consent to the Vaccination:

I have read and I understand the information set forth in this form. Based on that understanding, I hereby consent for myself or my child/vaccine recipient, to a COVID-19 vaccination provided to me or my child/vaccine recipient.

Signature of Recipient of COVID-19 Vaccine	Date	Time

Signature of Parent/Guardian Recipient of COVID-19 Vaccine *(if recipient is under 18 or lacks capacity to consent)*	Date	Time