SHARED ELECTRONIC HEALTH RECORD

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PATIENT LABEL HERE

COVID-19 VACCINATION

I. **DESCRIPTION, PURPOSE AND EXPECTED BENEFITS OF VACCINE PROCEDURE**. I understand that I will receive a vaccine by needle injection, which is intended to reduce the chances of my becoming ill due to a COVID-19 infection. COVID-19 infections can have serious, life-threatening complications. Depending upon the particular COVID-19 vaccine, I may require either one or two injections. I agree to remain at the vaccination location for at least 15 minutes after the vaccine is administered so that I could be attended to if I had an adverse reaction to the vaccine.

II. **POTENTIAL RISKS AND LIMITATIONS ASSOCIATED WITH THE PROCEDURE.** I understand that I may experience soreness, redness, and/or swelling at the injection site. The other significant known and potential risks and benefits of the vaccine, and the extent to which such risks and benefits are unknown, is described in an FDA Emergency Use Authorization (EUA) Fact Sheet. I have received and read the Fact Sheet and a pre-vaccination checklist for the vaccine. If I have any further questions about the procedure, I will ask them before undergoing the vaccination. It is unclear how long any potential benefits of the vaccine may last; or whether it will be effective against mutating forms of the COVID-19 virus. I understand that I may still become ill with COVID-19, and may be able to transmit the virus to other individuals**. For this reason, the vaccine does not eliminate the need for physical masking, social distancing, and hand hygiene.**

III. **TREATMENT ALTERNATIVES.** I understand that I may refuse the COVID-19 vaccine. There currently are no known effective alternatives to prevent COVID-19 infections, other than physical masking, social distancing, and hand hygiene.

IV. **PRECAUTIONS/CONTRAINDICATIONS** *Vaccine may not be indicated depending on your responses.*

Fever or feeling ill today?	❑ No or ❑ Yes – if yes, then defer until feeling better.
History of an allergic reaction (e.g., anaphylaxis, hives, itching) to any component of this vaccine?	❑ No or ❑ Yes – if yes, then STOP, do NOT vaccinate.
History of any immediate allergic reaction to another vaccine?	❑ No or ❑ Yes – if yes, then consult with physician and consider deferral of vaccination.
History of any immediate allergic reaction to an injectable therapy or IV contrast?	❑ No or ❑ Yes – if yes, then consult with physician and consider deferral of vaccination.
History of anaphylaxis?	❑ No or ❑ Yes – if yes, then observe for 30 minutes.

V. **USE OF HEALTH INFORMATION.** I understand that record of this vaccine administration will be reported to the state and/or federal regulatory bodies. I authorize my COVID-19 vaccine record to be shared with my primary care physician; and to be used or shared for payment, quality of care, patient safety, and research purposes. Otherwise, the information will be handled in accordance with the MaineHealth Notice of Health Information Privacy Practices, available online at https://www.mainehealth.org/-/media/Maine-Medical-Center/Files/Psychiatry/Notice-Privacy-Practices-2017.pdf, with printed copies also available on request.

VI. **PHONE CONTACT.** I consent to being contacted by MaineHealth or its agents by telephone (cell or landline), text message, or voice message at the telephone number previously provided. This consent applies to those individuals who are acting on my behalf.

Emergency Contact Name: _____ **Emergency Contact Phone Number:** _____

Date _____ Time AM|PM _____ **X** Signature ❑ Patient ❑ Parent ❑ Guardian ❑ Authorized Representative _____ Printed Name _____

If by telephone consent given by: ❑ Patient ❑ Other _____ Phone number _____

Date _____ Time AM|PM _____ **X** Witness Signature (For phone consent or when patient is physically unable to sign) _____ Printed Name _____

Interpreter for: ❑ Sign Language ❑ Foreign Language ❑ Other _____ Print Name or identifying information _____

Date _____ Time 24 Hour _____ **X** Signature of Physician or Designee _____ Printed Name _____

For Staff Use Only:

❑ Patient **had** an immediate adverse reaction to the vaccine. ❑ Patient **did not** have an immediate adverse reaction to the vaccine.