Informed Consent for Immunization with COVID-19 Vaccine IHealthSC

_____ _____ M ____ F Other_____

Last Name First Name Middle Date of Birth Age Gender

_____(_____)_____

Home Address City State Zip Code Phone Number

Race (please circle): Asian Hispanic Black/African American Caucasian American Indian Other:_____

Ethnicity (please circle): Hispanic Non-Hispanic

Are you the subscriber of the insurance? _____Y _____N If No, Subscriber's Name: _____ Date of Birth: _____

Primary Care Provider:_____Phone Number:_____

SCREENING QUESTIONS:	**YES**	**NO**
Are you sick today?		
Have you ever received a dose of COVID-19 vaccine? If yes, what product did you receive? Date:_____		
Have you ever had an allergic reaction to a previous COVID-19 vaccine or any component of the COVID-19 vaccine, including polyethylene glycol (PEG) or polysorbate?		
Have you ever had an allergic reaction to another vaccine (other than COVID-19) or another injectable medication?		
Have you ever had a severe allergic reaction (anaphylaxis) to any food, pet, environmental allergen, oral medication, or latex? If yes, please list:		
Have you received a vaccine in the last 14 days?		
Have you received passive antibody therapy (monoclonal antibodies or convalescent plasma) as a treatment for COVID-19 in the last 90 days?		
Are you pregnant or breastfeeding?		

INFORMED CONSENT AND LIABILITY WAIVER: Please read carefully- *you are waiving certain rights*- and sign:

I, the undersigned, declare and state that I have read the *CDC Emergency Use Authorization Fact Sheet* provided to me today and understand the risks and benefits of the COVID-19 vaccine. I have reviewed my answers to the screening questions above with my primary care provider and have been advised I am eligible to receive this vaccine. In consideration of my desire to receive the vaccine I hereby waive any and all rights, claims or causes of action of any kind arising out of my participation in this activity and waive, release and forever discharge IHEALTH SC 1001 E Ogden Ave Naperville 60563 KSSC MEDICINE 326 W Maple Street Hinsdale IL 60521, and CHRIST CHURCH OF OAKBROOK 501 Oak Brook Road, Oak Brook IL 60523 and their employees, staff and volunteers from any physical, emotional and/or psychological injury that I may suffer as a result of my participation in this Vaccine Clinic. I declare and state that 1) I understand that participation is voluntary, 2) I am of legal age or authorized legal guardian to execute this consent, 3) I answered all questions truthfully to the best of my knowledge, 4) I will remain in the area for the prescribed 15 minutes of observation (30 minutes for high risk conditions as recommended by CDC standing orders) and that if I leave earlier I do so at my own risk and against medical advice, 5) the administration of this vaccine is subject to mandatory reporting to State and/or Federal authorities/immunization registries and I grant permission, and 6) I have had any questions answered prior to receipt of the vaccine.

Signature of Patient/Power of Attorney/Legal Guardian, Parent_____Date_____

For Office Use Only:

Manufacturer	Lot #	Expiration Date	Dose	Dose #	Route	Site Deltoid	EUA publ date
Janssen/ J&J	201A21A	06/23/2021	0.5ml	1	IM	R L	02/21

Injector's Name, Signature and Credentials:_____**Date**_____