

NAME \_\_\_\_\_ DATE \_\_\_\_\_

## Somerset Pediatric Group

### COVID-19 Vaccine Consent

#### FACTS ABOUT COVID-19 VACCINE:

- The coronavirus disease (COVID-19) is caused by a new virus (SARS-CoV-2). Not everything is known about this new virus, although we are aware that in some people it causes significant medical complications, including death. COVID-19 is known to be highly transmissible between people, especially when an individual is in close proximity to someone who has been infected, even if the infected person is not exhibiting any symptoms. For more information about the virus or COVID-19, please feel free to visit: <https://www.cdc.gov/coronavirus/2019-ncov/index.html> or <https://covid19.nj.gov/> and/or [www.rwjbh.org/COVID](http://www.rwjbh.org/COVID).
- This COVID-19 vaccine is currently being administered under an Emergency Use Authorization (“EUA”) by the U.S. Food and Drug Administration (“FDA”). An EUA is a tool that the FDA uses to allow use of products, such as this vaccine, without full FDA review in order to address a public health emergency. That means that the FDA has not completed all its reviews to approve the vaccine, but has determined that, even though the vaccine is experimental, there may be risks of using the vaccine, there are potential benefits due to a public health emergency such as the COVID-19 pandemic. The FDA issued a recipient fact sheet which was provided to you.
- You have the choice to accept or refuse the vaccine. At this time, it is not mandatory.
- You should NOT get the COVID-19 vaccine if it is contraindicated. Please read the COVID-19 fact Sheet provided carefully about those that should not get the COVID-19 vaccine.
- If you receive a COVID-19 vaccine that requires you to take two doses, you should NOT get a second dose of the COVID-19 vaccine if you have a severe allergic reaction. You Should NOT get a second dose of the COVID-19 vaccine if you have an immediate allergic reaction unless you have been evaluated and cleared by a physician\* to receive a second dose.
- For more information about vaccines, please feel free to visit: <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html>.

#### CONSENT TO RECEIVE THE COVID-19 VACCINE:

- I request and authorize Somerset Pediatric Group to administer the COVID-19 vaccine, including all doses required which will be provided at subsequent visits. I understand and acknowledge that no guarantees or assurances have been made to me concerning the COVID-19 vaccination.
- I have been provided the Vaccine Information Sheet (VIS) and/or the FACT SHEET FOR RECIPIENT AND CAREGIVERS for this COVID-19 vaccine under the FDA EUA authorized patient fact sheet for this COVID-19 vaccine and have read it and understood it.
- I understand that this COVID-19 vaccine is being administered under an EUA. That means that FDA has not yet approved this COVID-19 vaccine for use generally but has authorized it to be used in this public health COVID-19 emergency and that authorization has been accepted by the Centers for Disease Control & Prevention (CDC). I also understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s), and over time unexpected side effects and complications may arise. I understand that I may react differently to the COVID-19 vaccine than other people.
- If I have any medical conditions/ complications such as allergies, or am immunosuppressed or pregnant or breastfeeding, I should specifically discuss with my treating physician the risks and benefits of receiving the COVID-19 vaccine. If I experience any immediate allergic reaction after the first dose of any COVID-19 vaccine that requires a second dose, I agree and acknowledge that by consenting to the second dose of the COVID-19 vaccine, I have been evaluated and cleared by a physician\* to receive a second dose.
- I understand that if I am demonstrating any adverse reactions to the COVID-19 vaccination, I should immediately contact my physician and/or go to a hospital emergency room.

#### ➤ GENERAL CONSENT:

- In consideration of being administered the COVID-19 vaccine, I hereby assign all rights, title, and interest in any health care insurance policy, as it pertains to these medical and/or physician services to the Hospital. I authorize and request payment directly to the Hospital of all monies and/or benefits to which I may be entitled from government agencies, insurance carriers, self-funded employer plans, or others who are financially liable for my medical care and treatment to cover the costs of care and treatment, including for health insurance benefits payable under terms of my policy or self-funded welfare benefit plan. I hereby authorize the release of any/all medical records about me for the purposes of payment of the services rendered to me. In the event that any healthcare provider, volunteer, or first responder (including emergency medical service workers and police officers) involved in my care is exposed to my blood or bodily fluids and makes a request for testing and results of such testing, I consent to the drawing of blood for the purpose of testing it for various blood-borne pathogens including, but not limited to,

Human Immunodeficiency Virus (HIV) and Hepatitis B and C. I understand and agree that the results of the blood test shall be released to me, the healthcare provider/first responder exposed to my blood or bodily fluids. To the extent possible, these results will be provided to the healthcare provide/ volunteer/first responder without disclosing my name.

On behalf of myself, my heirs and personal representatives, I, the undersigned, hereby release and hold harmless Somerset Pediatric Group and RWJBarnabas Health, Inc., its staff, volunteers, agents, successors, assigns, 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 COVID-19 vaccine, including creating and maintaining a medical record of this vaccination, as well as, any required reporting, including to the New Jersey Department of Health's New Jersey Immunization Information System (NJIS). Please note that these reporting agencies may also be required to report my vaccination information to other State and Federal authorities, as well as, storing, maintaining, disclosing, or use of my personal information. My signature below indicates that I consent to receive the COVID-19 vaccine.

I acknowledge receipt of the Notice of Privacy Practices. I confirm that I have read and fully understand the above. I agree that all of my questions have been answered fully and satisfactorily.

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**Print Patient's Name**                      **DOB**                      Signature (if less than 18 years old, parent or guardian must also sign below)

**PARENT / GUARDIAN CONSENT FOR MINORS (Under 18 years old)**

The undersigned parent and natural guardian or legal representative does hereby represent that he/she is, in fact, acting in such capacity, has consented to his/her child receiving the COVID-19 vaccine, and has agreed individually and on behalf of the child or ward, to the terms of this COVID-19 Vaccine Consent terms set forth above. I confirm that I have read and fully understand the above. I confirm that the above-referenced child is at least the minimum age required under the FACT SHEET FOR RECIPIENT AND CARE GIVERS FOR THIS COVID-19 vaccine. I agree that all of my questions have been answered fully and satisfactorily.

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Parent's Name

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Relationship to Patient

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

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