



Consent for COVID-19 Vaccine

Allergies: _____

Full Name (first and last) _____ Department _____

Address: _____

DOB: _____ Legal Gender _____ GenderID _____ Badge I D _____

Race:

- DECL - Declined
- AIA- Native American or Alaskan
- ASN - Asian
- BAA - African American or Black
- NHP - Native Hawaiian or Pacific Islander
- WHT - White OTH - Other or Multiracial

Ethnicity:

- DECL - Declined
- HIS - Hispanic Origin
- NHL - Non-Hispanic Origin
- UNK - Unknown

Please Check:

- MMC Employee
- MMC Student
- EMS
- Police
- Licensed independent provider
- MMC Volunteer
- Fire
- Other _____

1. Pregnant or suspect to be Pregnant, or currently breastfeeding?:
Yes No
2. Are you feeling Sick today?
Yes No
3. Have you ever had a serious or life threatening allergic reaction, such as hives or difficulty breathing to any vaccine or shot?
Yes No
4. Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?
Yes No
5. Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatment?
Yes No

Emergency Use Authorization Statement:

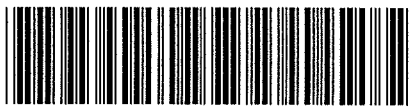
I have received the Vaccine information on the Emergency Use Authorization (EUA) and understand that this vaccine has been made available under an EUA. The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during emergencies, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing the known and potential benefits of the vaccine outweigh the known and potential risks.



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* C O N S V A C C I N E *

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- The COVID-19 Vaccination will reduce the chance of you suffering from COVID-19 disease. Like all medicines, no vaccine is completely effective and it takes a few weeks for your body to buildup protection from the vaccine. Some people may still get COVID-19 despite having a vaccination, but this should lessen the severity of any infection.
- The COVID-19 Vaccine cannot give you COVID-19 infection, and two doses will reduce your chance of becoming seriously ill. You will still need to follow the guidance of wearing correct personal protection equipment and taking part in any screening programs. Like all medicines, vaccines can cause side effects.
- Most of these are mild and short term and not everyone gets them. Soreness, redness, and swelling where the shot is given, fever, muscle aches and headache can happen after receiving the vaccine.
- While there have been no specific studies in these groups, there is no contraindication to receipt of the vaccine for pregnant or breastfeeding women. Pregnant or breastfeeding women should discuss potential benefits and risks of vaccination with their healthcare provider.
- You should not receive the COVID-19 vaccine if you have allergies to other types of vaccines and should talk to your doctor first. If you have an allergy to any of the ingredients in a COVID-19 vaccine, such as polysorbate, you should not receive the COVID-19 vaccine. If you have an allergy to PEG, you should not receive the vaccine. If you had an immediate allergic reaction after getting the first dose of the COVID-19 vaccine, you should not receive the second dose. If you have allergy to other types of vaccines, discuss with your doctor before receiving the COVID-19 vaccine.
- An allergic reaction can occur after receiving a vaccination. If you see signs of a severe allergic reaction, such as hives, swelling of the face and throat, difficulty breathing, fast heartbeat, dizziness, or weakness call 9-1-1 or seek emergent medical help immediately.
- Immunocompromised persons, including individuals receiving immunosuppressant therapy, may have a diminished immune response to the COVID-19 vaccine

I have received a copy of the Fact Sheets for recipients

Patient Signature: _____ Date: _____

	Date of COVID-19 Vaccination	Site of Injection (circle)		Lot #	Expiration	Manufacturer	Immunizer Name	Immunizer Signature
First		Left Arm	Right Arm					
Second		Left Arm	Right Arm					

Dosage: Pfizer / BioNTech 0.3mL

- I have reviewed the side effects with the patient (and parent, guardian or surrogate, as applicable)
- I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccine, and all the questions asked by them (and / or their surrogate, if applicable) have been answered correctly and to the best of my ability

EUA Fact Sheet Date: December 2020