ARKANSAS
HEART HOSPITAL

CONSENT FOR COVID-19 VACCINE

Name (*Print legibly*):	**AHH Employee (*circle*): Yes or No**
Contact Number:	**Date of Birth:**

1. **I have received and reviewed the Vaccine Fact Sheet and have had an opportunity to ask any questions that I may have regarding the vaccine.**
2. I have received no guarantee that I may not experience some side effects from the vaccine(s).
3. I have voluntarily requested that I receive the vaccine and I understand that I am under no pressure to do so.
4. I release the hospital and its employees from any and all liability or any injury, condition or damage incurred due to my receipt of the vaccine.
5. The FDA has authorized this vaccine to be given under Emergency Use Authorization (EUA).

Yes	No	
		1. Do you have a severe allergy to any food or medicine?
		2. Do you have a severe allergy to any vaccine?
		3. I have had a severe allergic reaction to any ingredient/s in the Pfizer-BioNTech COVID-19 vaccine.
		4. Have you had any vaccines within the previous 14 days? Pfizer-BioNTech or Moderna COVID-19 vaccine should be administered alone with minimal interval of 14 days before or after any other vaccine.
		5. Do you have a fever today? Are you sick today? Do you have COVID-19 infection and are currently in isolation? Are you currently in quarantine for known exposure to COVID-19?
		6. Are you pregnant, breastfeeding or planning to become pregnant? Women in this group may receive Pfizer- BioNtech or Moderna COVID-19 vaccine, a discussion with your healthcare provider can help make informed decision.
		7. Are you immunocompromised or have HIV, cancer, chronic kidney, lung, heart disease, sickle cell, severe obesity, do you smoke or have diabetes mellitus? Are you receiving any immunosuppressive therapy? These individuals may still receive Pfizer-BioNTech or Moderna COVID-19 vaccine unless otherwise contraindicated.
		8. Have you received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment? Pfizer-BioNTech or Moderna COVID-19 vaccine should be deferred for at least 90 days to avoid interference of treatment with vaccine-induced immune responses.
☐		**Yes, I would like to have the COVID-19 vaccination given to me.** I authorize designated staff of Arkansas Heart Hospital to administer the vaccine. I understand that after I receive the vaccine, I should look for potential reaction, such as: injection site pain, swelling, or redness, tiredness, headache, muscle pan, chills, joint pain, fever, feeling unwell, swollen lymph nodes There is a chance the vaccine could cause a severe allergic reaction. Signs of severe allergic reaction include: difficulty breathing, swelling of your face and throat, fast heartbeat, bad rash all over your body, dizziness and weakness I understand that if I develop a severe reaction, I should: seek medical attention immediately or call 911
☐		**To be effective, the vaccine must be administered in two doses approximately 21 days apart.** **I want to receive the full course of the COVID-19 vaccine.**

_____ _____

Signature **Date**

THE FOLLOWING SECTION TO BE COMPLETED BY IMMUNIZATION PROVIDER

Date of Vaccine	Site injection please circle	Route	Dose (ml)	Lot Number/ Expiration Date	Manufacturer
First:	L Arm R Arm				
Second:	L Arm R Arm				

Administered by (please print): _____ **Date:**_____ **Time:**_____

Signature: _____