COVID-19 VACCINE INFORMED CONSENT - RESIDENT/CLIENT

COVID-19 is the disease/illness that is caused by the introduction of the SARS-CoV-2 coronavirus into the human body. This virus spreads very easily from person to person, mainly through respiratory droplets produced when an infected person talks, sings, coughs or sneezes. These very small droplets can land in the mouths, noses and/or eyes of persons standing close by as well as within 6-12 feet of the infected person. It can also be transmitted by touching a contaminated surface then touching your face, eyes, nose, ears or mouth.

CLINICAL SYMPTOMS

The major symptoms of COVID-19 illness are fever, cough, trouble breathing, shortness of breath, congestion, new loss of taste or smell, sore throat, runny nose, general body and muscle aches, and headache. You can also experience flu-like symptoms such as vomiting, nausea and diarrhea. Symptoms may appear 2-14 days after exposure to the virus. A person does not have to be sick or have symptoms to transmit the virus to other people.

POPULATIONS THAT SHOULD RECEIVE THE COVID-19 VACCINE

CDC recommends the COVID-19 vaccine for persons 6 months of age and older. The vaccine is strongly recommended for healthcare workers, residents in LTC and other senior congregate living communities, persons 65 years of age and older as well as persons, including children and teens, with serious underlying medical conditions such as diabetes, heart disease, chronic lung disease, asthma, chronic kidney and/or liver disease, severe obesity, immune deficiencies/immunocompromised, bone marrow or organ transplant recipients, persons undergoing cancer treatment and smokers.

WHO SHOULD **NOT** RECEIVE THE COVID-19 VACCINE OR SHOULD WAIT

It is not currently recommended for these individuals to get the COVID-19 vaccine:

- Current fever or currently ill.
- Severe allergic reaction (e.g., anaphylaxis) after a previous dose of a COVID-19 vaccine or any of its components.
- Severe allergic reaction to any ingredient of this vaccine.

If in doubt or you have questions, please consult your physician.

CLINICAL SIDE EFFECTS OF COVID-19 VACCINE

A vaccine, like any medicine, can cause an adverse reaction, such as severe allergic reactions. However, the risk of a vaccine causing serious harm or death is extremely low.

Common side effects include:

- Pain, redness, tenderness or swelling at the site of the injection.
- Fever, fatigue, headache, nausea, joint pain, muscle aches, tiredness, and chills.

These symptoms usually occur within the first three (3) days of vaccination and resolve within 1-3 days of onset.

NAME–Last	First	Middle	MR #

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VACCINE INFORMATION (FACT SHEETS) PROVIDED TO RESIDENT/CLIENT

❍ **Pfizer-BioNTech Vaccine: Fact Sheet Available at:**
https://www.fda.gov/media/167212/download?attachment

❍ **Moderna Vaccine: Fact Sheet Available at:**
https://www.fda.gov/media/167209/download?attachment

❍ **Novavax Vaccine: Fact Sheet Available at:**
https://www.fda.gov/media/159898/download?attachment

VACCINE ACCEPTANCE

❍ I have received information regarding COVID-19 infection and have been educated on the benefits and risks associated with the selected COVID-19 vaccine. I hereby give permission and request that this vaccine be administered to me or the person named for whom I am authorized to sign.

_____ _____
Resident or Client/Legal Representative Signature Date Signed

_____ _____
Witness Signature/Title Date Signed

REASON FOR VACCINE DECLINE (Medical or Personal Reasons)

❍ I have received information regarding COVID-19 infections and have been educated on the benefits and risks associated with these vaccines. I hereby **DECLINE** to receive any COVID-19 vaccine for the following reason(s):

A. Medical Contraindication(s): Check all that apply
(Physician needs to be informed of medical conditions)

❑ Previous Hx of severe reaction to this vaccine

❑ Febrile illness at this time (Temp 101.5° F or 38.6° C)

❑ Other personal reason(s), specify:_____

B. Personal Reason(s): Check all that apply
(Physician needs to be informed of personal reasons)

❑ Perceived vaccine ineffectiveness

❑ Fear of needles/injections

❑ Fear of side effects

❑ Other personal reason(s), specify:_____

_____ _____
Resident or Client/Legal Representative Signature Date Signed

_____ _____
Witness Signature/Title Date Signed