COVID-19 VACCINATION
CONSENT FORM

COVID-19 VACCINE:

COVID-19 vaccines will help prevent disease that can be dangerous, or even deadly. Authorization for approved vaccines will help reduce the risk of disease by working with the body's natural defenses to safely develop protection (immunity) to disease. COVID-19 vaccines help develop immunity to the virus that causes COVIV-19 without us having to get the illness. It typically takes a few weeks for the body to develop immunity to the virus after vaccination. Therefore, it is possible that a person could be infected with the virus that causes COVID-19 just before or just after vaccination and then get sick because the vaccine did not have enough time to provide protection.

Sometimes after vaccination, the process of building immunity can cause symptoms, such as fever. There symptoms are normal and are a sign that the body is building immunity. The vaccine is NOT a live virus and will not give you COVID-19.

RISK & POSSIBLE SIDE EFFECTS:

COVID-19 vaccines have shown to generally cause only mild side effects. Most commonly, reactions may be soreness or tenderness at the injection site, fever, chills, fatigue, headaches or muscle aches. These effects usually last 24 to 48 hours. There is a possibility, as with any vaccine or drug, that an allergic or other serious reaction, or even death, could occur. Moreover, medical events completely unrelated to vaccine administration may occur coincidentally in the period following vaccination.

SPECIAL NOTICE: At this time, the COVID-19 vaccine is generally NOT recommended for the following people:

1. Children less than 16 years old for the Pfizer BioTech COVID-19 vaccine;
2. Children less than 18 years old for the Moderna and the Johnson & Johnson/ Janssen COVID-19 vaccine;
3. See FDA EUA Patient Fact Sheet for a full list of contraindications and precautions per manufacturer.

If any categories above apply to you, please notify the staff. If you have any questions, please ask now, or check with your physician or health department before receiving a vaccine.

IF YOU EXPERIENCE ANY SIGNIFICANT REACTIONS, CONTACT YOUR PHYSICIAN.

I have read the above information about COVID-19 and the COVID-19 Emergency Use Authorization (EUA) patient fact sheet with patient education information, and I have had a chance to ask questions. I understand the benefits and risks of the COVID-19 vaccination, and request that the vaccine be given.

Name: _____
Date of Birth: _____
(print)
Phone Number: _____

Signature: _____
Date: _____

ONLY MEDICARE PATIENTS ARE REQUIREDD TO SIGN THIS FORM:

Statement of Permit Payment of Medicare Benefits to Provider and Patient—Assignment of Benefits

Beneficiary Name: _____

Medicare #: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Autauga Pharmacy. I authorize any holder of medical or other information about me to release to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits for related services.

I attest to be offered the patient Bill of Rights, Quality Standards and Supplier Standards, and to being made aware of any product warranty that is available.

Item(s)/Service(s) Provided:

(1) Janssen Covid 19 Vaccination

Beneficiary Signature: _____

Date: _____