# COVID-19 Vaccination Informed Consent Form

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|---|---|---|
| First Name: | Last Name: | Date of Birth: |
| Address: | City, State: | Zip: |
| Gender: ☐ Male ☐ Female | Home Phone: | Cell Phone: |
| Physician Name: | City: | |
| Race/Ethnicity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino American ☐ Pacific Islander ☐ White ☐ Other, specify: | | |

**I want to receive the following immunization**: ☐ COVID-19 (SARS-CoV-2 Vaccine) - 2 Dose Series

| PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE BOXES | YES | NO | DON'T KNOW |
|---|---|---|---|
| 1) Are you sick today? (For example fever, chills, cough, shortness of breath, difficulty breathing, new loss of taste or smell, fatigue, muscle or body aches, etc.) | | | |
| 2) Have you ever received a dose of COVID-19 vaccine? | | | |
| 3) Have you had a severe allergic reaction (e.g. anaphylaxis, trouble breathing) to any vaccine or injectable therapy, or a history of anaphylaxis due to any cause? | | | |
| 4) Have you recevied any vaccines in the past 14 days? | | | |
| 5) Have you ever tested positive for COVID-19 or has a doctor ever told you that you had COVID-19? | | | |
| 6) Have you received COVID antibody or convalescent plasma as treatment for COVID-19 in the past 90 days? | | | |
| 7) Do you have a weakened immune system caused by something such as HIV, infection or cancer or do you take immunosupressive drugs or therapies? | | | |
| 8) Do you have a bleeding disorder or are you taking a blood thinner? | | | |
| 9) For women, are you preganant or breast feeding? | | | |

I agree that Big Y Pharmacy will notify my physician of vaccine received. If applicable, I give Big Y Pharmacy permission to bill Medicare Part B on my behalf for vaccine.

I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent COVID-19.

I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine. I understand the risks and benefits associated with the above vaccine and have received and read the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation and up to 30 minutes if deemed necessary due to previous anaphylactic reaction.

I understand the benefits and risks of the vaccine and I consent to the administration of the vaccine.

Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators, and assignees, Big Y Foods, Inc. and their employees, owners, and representatives from any and all claims, demands, actions, and causes of action, which may result from participation in this program. I will communicate the information provided to me today about my vaccination to my primary care provider if I have one.

**Signature: _____** **Date: _____/_____/_____**