

COVID-19 VACCINE-PFIZER (Age 12 years & Over)
COVID-19 VACCINE-MODERNA (Age 18 Years & Over)
COVID-19 VACCINE-NOVAVAX (Age 18 Years & Over)

SAINT LOUIS UNIVERSITY
 CONSENT TO TREAT/ ASSIGNMENT/ RELEASE

MEDICAL HISTORY ACKNOWLEDGEMENT

I have read and been offered to receive a copy of the current *COVID-19 Emergency Use Authorization Fact Sheet* (rev. 7/2022) prior to my vaccination. I understand all the risks and benefits involved and I have had a chance to ask questions. • I agree to stay in the general area for 15 minutes after receiving my vaccination to ensure that no immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. Mild reactions may include pain, tenderness and swelling of the lymph nodes in the same arm of the injection, swelling (hardness), and redness. General side effects may include fatigue, headache, muscle pain, joint pain, chills, nausea and vomiting, and fever. Severe reactions may include difficulty breathing, swelling of your face and throat, a fast heartbeat, a bad rash all over your body, dizziness, and weakness. • I have been offered a flyer on how to enroll on **V-Safe** • I hereby release and hold harmless Saint Louis University, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors, volunteers, and employees, from any and all liabilities or claims whether known or unknown arising out of, or in connection with, or in any way related to the administration of the vaccine(s) listed above.

ASSIGNMENT OF BENEFITS

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICIP to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICIP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use of covered countermeasures identified in a PREP Act declaration. The PREP Act declaration for medical countermeasures against COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV-2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any such product. Information about the CICIP and filing a claim is available by calling 1-855-266-2427 or visiting

<https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/comirnaty-and-pfizer-biontech-covid-19-vaccine>

or

<https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/spikevax-and-moderna-covid-19-vaccine>

or <https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/novavax-covid-19-vaccine-adjuvanted>

COMPLETE ALL INFORMATION BELOW TO RECEIVE COVID VACCINE

RELEASE OF INFORMATION

I authorize SLU to release all records and information concerning my vaccination to my employer, to any third-party payer, to any other health care provider and to any Federal or State governmental agency, to facilitate compliance with law.

First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>

Address Number	Street Name	Sex M/F/T/O
<input type="text"/>	<input type="text"/>	<input type="text"/>

City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>

Age	Date of Birth (MM/DD/YY)	Area Code	Phone Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Email
<input type="text"/>

Race: White African American/Black Asian Am. Hawaiian/Pacific Islander American Indian Two or More Races

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

(Initials) I have read and been offered to receive a copy of the Notice of Privacy Practices prior to services, and I have had the opportunity to have my questions answered.

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HEALTH HISTORY

If answering YES or Unknown to Questions 1, 2, 3, 7, 8, please Contact Your Physician Prior To Your Appointment For Approval To Receive COVID-19 Vaccine

	<u>YES</u>	<u>NO</u>	<u>UNKNOWN</u>
1. Are you moderately or severely ill today including a temperature of over 100 degrees? (mild illness or taking antibiotics are not reasons to withhold vaccination)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any allergies that require you to carry an EPI-pen or to latex, foods, medications, or vaccines? (products containing polyethylene glycol such as laxatives like MiraLAX/Golytely) If yes, please list _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after a vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In the past 60 days have you: Tested Positive for COVID-19? NOTE: You may not be able receive a COVID-19 vaccine during this period.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you received passive antibody therapy for COVID-19 in the past 90 days? NOTE: If yes, you cannot receive a COVID-19 vaccine during this period.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you breastfeeding, pregnant, or planning on becoming pregnant in the next 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. In the past 3 months, have you taken medication that affects your immune system? Such as prednisone, other steroids, anticancer drugs, drugs for treatment of rheumatoid arthritis, Crohn's disease or psoriasis; or have you had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you currently have or have you had a history of neurological condition, seizure or have ever had Guillain Barre Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you received any vaccinations in the past 14 days? NOTE: You should not receive the Novavax vaccine 14 days prior or after receiving your COVID-19 vaccine.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past year, have you received a dose of COVID-19 vaccine? If yes, date of first dose _____ date of second dose _____ date of third dose _____ and what brand (circle) Pfizer / Moderna / Novavax/ Janssen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I have read this consent and I authorize SLU to give COVID-19 vaccine to the person named above for which I am authorized to sign.

/ / X /
 Date Signature of Person, Parent or Legal Guardian receiving vaccine / Relationship to Patient

Clinic ID#	X _____ Nurse Signature	_____ / _____ / _____ Date Given	Dose Number 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Booster 1 <input type="checkbox"/> Booster 2 <input type="checkbox"/>	IM Site Given Deltoid L • R
Manufacturer (Circle One): Moderna Pfizer Novavax		Lot Number: _____ Exp Date: / /		