

COVID-19 Vaccine Consent

FACTS ABOUT COVID-19 VACCINE:

- The coronavirus disease (COVID-19) is caused by a new virus (SARS-CoV-2). Not everything is known about this new virus, although we are aware that in some people it causes significant medical complications, including death. COVID-19 is known to be highly transmissible between people, especially when an individual is in close proximity to someone who has been infected, even if the infected person is not exhibiting any symptoms. For more information about the virus or COVID-19, please feel free to visit: <https://www.cdc.gov/coronavirus/2019-ncov/index.html> or <https://covid19.nj.gov/> and/or www.rwjbh.org/COVID.
- Some COVID-19 vaccines are FDA approved for certain uses and some COVID-19 vaccines that are currently being administered are under an Emergency Use Authorization (“EUA”) by the U.S. Food and Drug Administration (“FDA”). An EUA is a tool that the FDA uses to allow use of products, such as some COVID-19 vaccines, without full FDA review in order to address a public health emergency. That means that the FDA has not completed all its reviews to approve the vaccine, but has determined that, even though the vaccine is experimental, there may be risks of using the vaccine, there are potential benefits due to a public health emergency such as the COVID-19 pandemic. If the vaccine you are receiving is under an EUA, you will be provided access to a document titled “FACT SHEET FOR RECIPIENT AND CAREGIVERS.” If the vaccine you are receiving is FDA approved, then you will be provided access to a Vaccine Information Sheet (VIS).
- You have the choice to accept or refuse the vaccine.
- You should NOT get the COVID-19 vaccine if it is contraindicated. Please read the COVID-19 Fact Sheet and/or VIS provided carefully about those that should not get the COVID-19 vaccine.
- If you receive a COVID-19 vaccine that requires you to take a two-dose series, and/or recommends a third dose, and/or recommends Boosters, you should NOT get an additional dose of that COVID-19 vaccine, if you have a **severe allergic reaction** to a prior dose. You should also NOT get additional doses of that COVID-19 vaccine, if you have an **immediate allergic reaction** unless you have been evaluated and cleared by a physician* to receive a such a dose.
- You should only receive recommended third dose if you have a moderate or severely compromised immune system and have completed either the Pfizer-BioNTech and/or Moderna vaccine series at least 28 days prior.
- Regarding boosters:
 - For those at least 18 years of age, you should get a single shot of the recommended COMIRNATY (COVID19 Vaccine, mRNA), Pfizer-BioNTech COVID-19, SPIKEVAX (COVID-19 Vaccine, mRNA), Moderna, or Janssen vaccine (“**Booster**”) if you have (i) received the primary series of the **Pfizer-BioNTech COVID-19 Vaccine or COMIRNATY (COVID19 Vaccine, mRNA) or SPIKEVAX (COVID-19 Vaccine, mRNA) or Moderna Vaccine** at least five (5) months of completing the series or the Janssen Vaccine at least two (2) months ago (each an “Eligible Booster Recipient”).
 - For those at least 18 years of age, you may mix and match the Booster dose. That is, you may receive a Booster or one of the other COVID-19 vaccines stated here once you have completed your primary vaccination with a different vaccine **after** the waiting period for your primary vaccine. So, for example, if your primary vaccine was Janssen, after at least 2 months, you may receive either a Janssen, Pfizer or Moderna Booster. Further, if your primary series vaccine was Pfizer or Moderna, after 5 months of completing the series you may receive either a Janssen, Pfizer, or Moderna Booster.
 - For those at least 12 years of age but less than 18 years of age and an Eligible Booster Recipient, you may receive **only a single shot of the Pfizer-BioNTech COVID-19 Vaccine or COMIRNATY (COVID19 Vaccine, mRNA) booster after** the five (5) month waiting period from completing your primary series of the **Pfizer-BioNTech COVID-19 Vaccine or COMIRNATY (COVID19 Vaccine,mRNA).**
- For more information about vaccines, please feel free to visit: <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html>.

CONSENT TO RECEIVE THE COVID-19 VACCINE:

- I request and authorize Monmouth Medical Center (the “Hospital”) and its employees, volunteers, attending physician(s) and such associates, assistants and/or residents as may be selected by the said physician(s), and all the persons to administer the COVID- 19 vaccine, including all doses required which will be provided at subsequent visits. I understand and acknowledge that no guarantees or assurances have been made to me concerning the COVID-19 vaccination.
- I have been provided the Vaccine Information Sheet (VIS) and/or the FACT SHEET FOR RECIPIENT AND CAREGIVERS for this COVID-19 vaccine under the FDA EUA authorized patient fact sheet for this COVID-19 vaccine and have read it and understood it.
- I understand that I may be receiving either a COVID-19 vaccine being administered under an EUA or that is FDA approved. For an EUA vaccine, that means that FDA has not yet approved this COVID-19 vaccine for use generally but has authorized it to be used in this public health COVID-19 emergency and that authorization has been accepted by the Centers for Disease Control & Prevention (CDC). I also understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s), and over time unexpected side effects and complications may arise. I understand that I may react differently to the COVID-19 vaccine than other people.
- If I have any medical conditions/ complications such as allergies, or am immunosuppressed or pregnant or breastfeeding, I should specifically discuss with my treating physician the risks and benefits of receiving the COVID-19 vaccine. If I experience any immediate allergic reaction after the first dose of any COVID-19 vaccine that requires a second dose, I agree and acknowledge that by consenting to

* Consider a referral to an allergist-immunologist



- the second dose of the COVID-19 vaccine, I have been evaluated and cleared by a physician* to receive a second dose.
- I understand that if I am demonstrating any adverse reactions to the COVID-19 vaccination, I should immediately contact my physician and/or go to a hospital emergency room. I also grant permission to be contacted by a representative of RWJBarnabas Health, including Barnabas Health Medical Group.
- I understand that by requesting a recommended third dose, I attest that I have a moderate or severely compromised immune system and/or otherwise qualified for a third dose and I had received two doses of either the Pfizer-BioNTech and/or Moderna already. I also understand and agree that for the recommended third dose, I may receive either the Pfizer-BioNTech or Moderna vaccine and not necessarily the same as what I received for the first and second dose of the vaccine, as available at the site.
- I understand that by requesting a Booster, I attest that I am an Eligible Booster Recipient.

GENERAL CONSENT:

- In consideration of being administered the COVID-19 vaccine, I hereby assign all rights, title, and interest in any health care insurance policy, as it pertains to these medical and/or physician services to the Hospital. I authorize and request payment directly to the Hospital of all monies and/or benefits to which I may be entitled from government agencies, insurance carriers, self-funded employer plans, or others who are financially liable for my medical care and treatment to cover the costs of care and treatment, including for health insurance benefits payable under terms of my policy or self-funded welfare benefit plan. I hereby authorize the release of any/all medical records about me for the purposes of payment of the services rendered to me. In the event that any healthcare provider, volunteer, or first responder (including emergency medical service workers and police officers) involved in my care is exposed to my blood or bodily fluids and makes a request for testing and results of such testing, I consent to the drawing of blood for the purpose of testing it for various blood-borne pathogens including, but not limited to, Human Immunodeficiency Virus (HIV) and Hepatitis B and C. I understand and agree that the results of the blood test shall be released to me, the healthcare provider/first responder exposed to my blood or bodily fluids. To the extent possible, these results will be provided to the healthcare provide/ volunteer/first responder without disclosing my name.
- I grant permission and consent to the Hospital, its assignees, all clinical providers involved in administering the COVID-19 vaccine (1) to send me text messages or emails using any email addresses I provide and; (2) to use pre-recorded/ artificial voice messages and/or an automatic dialing device (an auto-dialer) in connection with any communications made to me or any related scheduled services.
- I understand that the Hospital or its designees may contact me as part of its' fundraising activities, as permitted by law. I have the right to tell them not to send me future fundraising communications.
- I hereby authorize and consent to RWJ Barnabas Health, Inc., and its affiliates, including the Hospital, and their employees and agents ("RWJBH") taking, recording, including through zoom meetings or otherwise, and using any photographs, moving pictures, videos of me, including events, whether in-person or virtually, including any RWJBH events, such as COVID vaccine clinics ("Images") in any manner RWJBH chooses in its sole discretion, including use of any or all portions of my name and the Images in displays, publications, distribution, transmission, disclosing to media, streaming, including printed materials, internet, video, dvd, and cd or other form of distribution. I hereby agree that the RWJBH will not be required to pay any consideration or seek any additional approval in connection with such use of name and Images. I hereby irrevocably release, waive and forever discharge any and all claims, causes of action, demands, damages, rights, remedies, liabilities and obligations of whatever kind or character that I may have had, may now have, or may later assert (at law, in equity or otherwise) against the RWJBH arising pursuant to, in connection with or related in any way to the taking, use or disclosure of names and Images or any portion or aspect thereof.

On behalf of myself, my heirs and personal representatives, I, the undersigned, hereby release and hold harmless RWJBarnabas Health, Inc., its staff, volunteers, agents, successors, assigns, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the COVID-19 vaccine, including creating and maintaining a medical record of this vaccination, as well as, any required reporting, including to the New Jersey Department of Health's New Jersey Immunization Information System (NJIS). Please note that these reporting agencies may also be required to report my vaccination information to other State and Federal authorities, as well as, storing, maintaining, disclosing, or use of my personal information. My signature below indicates that I consent to receive the COVID-19 vaccine.

I acknowledge receipt of the Notice of Privacy Practices. I confirm that I have read and fully understand the above. I agree that all of my questions have been answered fully and satisfactorily.

Print Patient's Name DOB Signature (if less than 18 years old, parent or guardian must also sign below) Date

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PARENT / GUARDIAN CONSENT FOR MINORS (Under 18 years old)

The undersigned parent and natural guardian or legal representative does hereby represent that he/she is, in fact, acting in such capacity, has consented to his/her child receiving the COVID-19 vaccine, and has agreed individually and on behalf of the child or ward, to the terms of this COVID-19 Vaccine Consent terms set forth above. I confirm that I have read and fully understand the above. I confirm that the above-referenced child is at least the minimum age required under the VIS and/or FACT SHEET FOR RECIPIENT AND CARE GIVERS FOR THIS COVID-19 vaccine. I agree that all of my questions have been answered fully and satisfactorily.

Patient Authorized Representative Name

Relationship to Patient**

Patient Authorized Representative Signature***

Date

Witness Name

Date

Witness Signature

Address: _____

Phone: _____

**If you are the healthcare agent or guardian, please provide proof of your authority to act on behalf of the patient.

*** If you are completing this form in-advance of the appointment, your signature must be witnessed. Please have a witness sign and date above.