TRIHEALTH COVID-19 VACCINE AND PHI CONSENT

Name of person receiving vaccine (please print) _____ DOB ___/___/___ Age _____

I understand that the COVID-19 vaccine that is being administered to me is offered through an **Emergency Use Authorization** (EUA) from the U.S. Food and Drug Administration (FDA). EUAs bypass the normal (longer) FDA authorization process to allow the use of unapproved medical products to treat or prevent serious diseases, such as COVID-19. EUAs are issued in response to a declared public health emergency when there is no available, approved alternative to treat or prevent a disease. When it issues an EUA, FDA determines that the known and potential benefits of the product outweigh its known and potential risks.

I understand there are multiple vaccines from multiple manufacturers that have been granted EUA approval. Though each vaccine is slightly different, they are all considered highly effective against COVID-19. These vaccines were granted EUA approval because no serious safety concerns were identified, and because the known and potential benefits outweigh the known and potential risks.

My signature below indicates I have read and understand the above, received a copy of the "Fact Sheet for Recipients and Caregivers," and understand the below:

1. I understand that the vaccine I am receiving was approved through an EUA.
2. I understand I must inform the person giving my vaccine if I have had any type of adverse effect from a previous dose of the COVID-19 vaccine or any of its components.
3. I understand that the data is insufficient to inform of the risks possibly associated with receiving the COVID-19 vaccine during pregnancy or lactation. I have discussed the risk/benefit of the vaccine with my personal physician before consenting to receiving the vaccine.
4. I understand that I must wait for 15 minutes after receiving the COVID-19 vaccine for observation of any immediate side effects that may need medical treatment.
5. I understand that I must wait for 30 minutes after receiving the COVID-19 vaccine if I have ever had a severe allergic reaction after receiving any vaccine, medication or food, including if I have been advised to carry emergency epinephrine (e.g., EpiPen).
6. I understand that in order to become immune, some vaccination brands require a series of two doses to be considered fully vaccinated. If a second dose of vaccine is required, it is my responsibility to schedule and appear for my scheduled second-dose appointment. I understand that if I fail to maintain my scheduled second-dose appointment, TriHealth cannot guarantee a replacement second-dose appointment will be able to be offered within the recommended timeframe of the first dose because it is anticipated that available slots may be limited or totally unavailable.
7. I understand that that my COVID-19 vaccination record will be sent to the Ohio Department of Health as required for the Impact-SIIS database.
8. I understand that studies show that it may take up to three weeks for me to become immune to COVID-19 after receiving the vaccine, as my body builds up its immunity. I also understand that how long I will remain immune following vaccination is unknown at this time.

I have been given an opportunity to ask any questions I may have, and I have freely and voluntarily agreed to be vaccinated.

I authorize TriHealth to disclose my vaccination information/ record to TriHealth's affiliated health care providers and facilities where I receive treatment (including scanning it into my medical record).

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Signature of person receiving vaccine or Parent/Guardian **Date**

Rev. 3/1/2021