MERITUS MEDICAL CENTER

Consent for COVID-19 Vaccine pursuant to Emergency Use Authorization (EUA)

Patient Name:				Date:	
Date of Birth:		Age:		MRN:	

The U.S. Food and Drug Administration (FDA) has issued emergency use authorizations (EUA) for several vaccines to prevent COVID-19, the disease caused by SARS-CoV-2. Like all medications, no vaccine is completely effective and it takes a few weeks after the vaccine for the body to build up protection. Some people may still get COVID-19 despite having a vaccination, but this vaccine may lessen the severity of any infection.

The vaccine cannot give a person COVID-19, and some vaccines require two doses to further reduce the chance of an individual becoming seriously ill or dying. A vaccinated individual will still need to follow CDC guidance to reduce transmission of SARS-CoV-2, such as washing hands frequently, keeping social distance and wearing a face mask when necessary. Like all medications, vaccines can cause side effects. Most of these are mild and short-term, and not everyone gets them.

1. I understand that the FDA has authorized emergency use of COVID-19 vaccines, which are not an FDA-approved vaccines.

2. I understand that consent for this vaccine is voluntary. I have the option to accept or refuse administration of the COVID-19 vaccine.

3. I have been given a copy of the **FDA's Fact Sheet for Recipients and Caregivers**, which includes information on the potential risks of the COVID-19 vaccine and have been given the opportunity to ask questions.

4. I understand that severe reactions are rare and that, if I were to experience a severe reaction, it is most likely to occur within 15 minutes of vaccine administration. It is recommended that I remain on-site at the vaccination site for 15 minutes to ensure clinical aid is nearby, should I experience a reaction.

5. I understand that, if my vaccine requires two doses for optimal efficiency, I will be given a vaccination card with a date to return for my second dose. I understand that it is my responsibility to return for the second dose.

I certify that I am of the appropriate age to receive the vaccine being administered to me. I understand that Meritus Medical Center, Inc. and its affiliates (collectively Meritus Health) are administering the vaccine. I hereby give consent to Meritus Health and its agents to administer the COVID-19 vaccine.

I understand that an administration fee may be billed to my insurer, if applicable. I authorize Meritus Health to bill any third party payers for this service and to release my medical information to such payers for the purposes of obtaining payment. I hereby assign and request payment for services be made directly to Meritus Health.

I understand that Meritus Health may use or disclose my medical information as permitted or required by law, including reporting administration of the vaccine to Maryland's immunization registry. Meritus Health's Notice of Privacy Practices includes further information on how my medical information may be used and is available on Meritus Health's website at www.meritushealth.com/about-us/privacy-practices/.

By signing below, I certify that I have read and understand the information above and consent to receive the COVID-19 vaccine. This consent shall remain valid for forty-five (45) days from the date of signature below.

Vaccine Administered	**Pfizer** ☐ **Moderna** ☐ **Janssen** ☐ **Other:**

Printed Patient Name: _____

Patient or Authorized Representative Signature: _____ Date: _____