Informed Consent and Release of Information Form

I voluntarily consent to and request that the COVID-19 vaccine be given to me. I represent that I lawfully can consent to receive health care services or that I can lawfully consent on behalf of the individual to be vaccinated (i.e., as a parent, guardian, or other legal relationship).

I understand that the COVID-19 vaccine may be administered in multiple doses. If my vaccine requires a series of doses administered through multiple injections, I understand and agree that these terms will apply to the entire vaccination series.

I understand that I must answer the series of health questions below before receiving this vaccine. I consent to answer each question truthfully before receiving the vaccine. Please check response:

	YES	NO
Do you currently have a fever or other Covid-19 symptoms?		
Have you been positive for Covid-19 in the past 90 days?		
Have you ever had a severe allergic reaction (e.g. anaphylaxis) after a vaccine?		
Have you received a Flu Vaccine or other vaccine in the past 14 days?		
Have you received a vaccination for Covid-19 in the past?		
Are you breastfeeding, pregnant, or plan to become pregnant in the next 3 months?		

I understand that if I am pregnant, breastfeeding, immunocompromised, taking a medication that affects my immune system, have a bleeding disorder, or on blood thinners that I should consult my healthcare provider regarding potential risks before receiving this vaccine. I voluntarily accept such risks and wish to proceed.

Although the COVID-19 vaccine may prevent me from contracting COVID-19, I understand that no vaccine can be guaranteed to be effective. The COVID-19 vaccine may not protect everyone, and the duration of any protection is unknown. I also understand that I may be receiving a vaccine that has been authorized for emergency use pursuant to an Emergency Use Authorization (EUA). In addition, I understand that the administration of any vaccine, including the COVID-19 vaccine, involves the risk of both short- and long-term side effects, including potentially serious or severe complications. Individuals who take the shot may feel some tenderness at the site of the injection, tiredness, muscle pain, headache, chills, joint pain, fever, injection site swelling, injection site redness, nausea, feeling unwell or swollen lymph nodes. The administration of this vaccine also could cause a severe allergic reaction in some individuals. I understand that it is not possible to predict all side effects or complications with receiving the COVID-19 vaccine. I understand the risks and benefits associated with the COVID-19 vaccine and assume the risks of all side effects.

I confirm that I have received and read, or had read to me, and fully understand the available federal information sheets on the EUA and/or the vaccine, including the FDA fact sheet concerning the vaccine and EUA and any vaccine information statements provided by the Centers for Disease Control and Prevention (CDC), if available at the time of my vaccination. I have had the opportunity to ask any questions I have regarding the vaccine, and those questions have been answered to my satisfaction. I have considered my health circumstances along with the risks and benefits of the COVID-19 vaccine, and I knowingly and voluntarily consent to accept this vaccine.

I agree to comply with any instructions at the vaccination site, including to remain for observation. Further, I agree to return in a timely fashion as instructed for any additional vaccine injections as necessary.

I consent to the disclosure of my information associated with the COVID-19 vaccine to any University of Alabama in Huntsville official or to officials of any affiliated, related, or associated entity as appropriate to respond to the COVID-19 pandemic, and to any entity or individual that may assist with payment, treatment, or healthcare operations. I also understand that my information may be disclosed as otherwise required or permitted by law.

_____ _____

Signature of Individual Authorizing Vaccine Printed Name of Individual Receiving Vaccine

_____ _____

UAH A# or Last 4 digits of SSN Printed Name of Individual Authorizing (If Different)

_____

Date of Birth of Individual Receiving Vaccine

_____

Date

REQUIRED: Demographics needed for reporting vaccinations to Alabama Department of Public Health:

Last Name:	First Name:	Gender:
Race: (circle one) White, Black or A.A., Asian, American Indian or Alaskan Native, Native Hawaiian or other Pacific islander, unknown, other, or Race Not Reported	Ethnicity: (circle one) Hispanic or Latino, Not Hispanic or Latino, or None specified	DOB: ___/____/_____ mm/dd/yyyy
Address:	City	County
State/Zip	Phone:	(circle one) Cell, home, or office

Affiliation of Individual Receiving Vaccine with UAH: Student □ Faculty/Staff □

Other_____

FOR OFFICE USE ONLY:

Manufactured by: /Lot#	LEFT arm or RIGHT arm
University of AL in Huntsville	
Date administered:	Administered by: