Prism Health Lab
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(800) 325-1812

COVID-19 Vaccination Consent Form

I have been given a copy and have read, or have had explained to me, the information in the **FACT SHEET** for the COVID-19 Vaccine that I will receive and this COVID-19 Vaccine Consent Form. I understand the FDA has authorized the emergency use of the COVID-19 Vaccine, which is not an FDA-approved vaccine. I understand there is currently not enough scientific evidence for the FDA to fully approve this or any COVID-19 Vaccine. I have had the chance to ask questions that were answered to my satisfaction. I have also been informed that I can access the V-Safe reporting tool from the Centers for Disease Control at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafe.html#anchor_1607560764339.

I understand the COVID-19 Vaccine will be provided to me at no charge.

I agree to stay in the vaccine administration area for fifteen (15) minutes (or longer if indicated by the vaccine administrator) after receiving my vaccination to ensure that no immediate adverse reactions occur, and I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician. I understand that the side effects reported in the clinical trials are summarized in the **FACT SHEET** for this COVID-19 vaccine. The side effects are not severe in most cases and usually resolve within 24 hours. If I have questions about side effects, I may call Prism Health Lab at (800) 325-1812 and request a virtual visit with a provider. I understand that certain severe allergic reactions have been reported outside of clinical trials; if I develop symptoms of an allergic reaction following vaccination (such as trouble breathing, chest pain, or a fast heartbeat, dizziness, weakness, swelling of face, throat, or tongue, or a rash all over the body), **I will call 911 or go to the nearest Hospital Emergency Department.**

I understand that I may be asked additional screening questions at my appointment prior to administration of the COVID-19 Vaccine as part of this consent process to determine my eligibility to receive the COVID-19 Vaccine and/or the need for any counseling for me concerning risk based on my responses.

I understand the significant known and potential risks and benefits of the COVID-19 Vaccine as explained in the FACT SHEET and that some of the potential risks and benefits may remain unknown, and **I REQUEST THE COVID-19 VACCINE BE GIVEN TO ME**.

IF CONSENTING FOR MINOR'S VACCINATION: I have reviewed the information about the COVID-19 Vaccine above and understand the risks and benefits. In providing my consent below, I agree that:

1. I have reviewed this consent form, and I understand that the **FACT SHEET** includes more detailed information about the potential risks and benefits of the COVID-19 Vaccine.
2. I have the legal authority to consent to have the child named below vaccinated with the COVID-19 Vaccine.
3. I understand I am not required to accompany the child named below to their vaccination appointment and that, by giving my consent below, the child will receive the COVID-19 Vaccine whether or not I am present at the vaccination appointment.
4. If I have health insurance that covers the child named below, I give permission for my insurance company to be billed for the costs of administering the COVID-19 Vaccine. The government is paying for the COVID-19 Vaccine itself, and I will not be billed for that portion of the cost of my child's immunization.
5. I understand that as required by state law, all immunizations will be reported to the Illinois Department of Public Health through the Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE). I can access the I-CARE Fact Sheet for Parents and Patients at https://dph.illinois.gov/topics-services/prevention-wellness/immunization/icare for information on I-CARE and what to do if I object to my or my family's data being shared with other providers in I-CARE.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Signature of Legally Authorized Representative: _____ Date: _____
<< Name of person signing >>