NorthShore University HealthSystem

Effective September 2021

COVID-19 VACCINE CONSENT FORM
53770-004 (9/2021)

Patient Name:	Date of Birth:	Date:

Please read this form carefully. This Consent form explains how NorthShore University HealthSystem, which includes but is not limited to, Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, Skokie Hospital, NorthShore Home and Hospice Services, NorthShore Immediate Care, certain organizations owned or controlled by NorthShore including, NorthShore Medical Group, Swedish Hospital, and Northwest Community Healthcare, along with its affiliated subsidiaries (together "NorthShore"), is currently administering COVID-19 vaccines. It is essential for you to acknowledge your understanding of this important information prior to receiving a COVID-19 vaccine at NorthShore.

Vaccine Administration: In support of NorthShore's emergency preparedness and COVID-19 countermeasure protocols, NorthShore is administering COVID-19 vaccines pursuant to applicable Authorizations from the U.S. Food and Drug Administration, which may include an Emergency Use Authorization (EUA) process. Under the EUA process, I understand there is limited data available about the short-term (duration of the study trial) safety of that vaccine which means that we don't know all of the potential side effects of the vaccine, particularly long-term (any time after the conclusion of the initial study period). Based on currently available data, I understand that possible known side-effects of the COVID-19 vaccines include:

a. Pain and redness at the injection site;
b. Feeling tired and run down in the 24 hours after receiving the vaccine;
c. Headache, muscle aches, chills, joint pains, or fever;
d. Possible allergic reactions in individuals known to have allergies.

Vaccine Eligibility and Preparedness: In order to be eligible to receive a COVID-19 vaccine at NorthShore, I understand that individual factors should be taken into consideration based on currently available safety and effectiveness data for the vaccines. As such:

I attest that I have not received a COVID-19 diagnosis within the last ten (10) days;

I attest that I am not currently experiencing any COVID-19 symptoms (including but not limited to: fever, shortness of breath, new loss of taste or smell, nausea or vomiting, diarrhea);

I attest that I have not received plasma or monoclonal antibody treatment for an active COVID-19 infection within the last 90 days.

Additionally, the Center for Disease Control and Prevention's ("CDC") Advisory Committee on Immunization Practices provides guidance for vaccination of special populations, including individuals who: (1) have serious allergies, and/or (2) moderately or severely immunocompromised or taking medications that impact immune response.

I understand and acknowledge that if I am within any special populations, I have reviewed current CDC guidance and/or obtained and reviewed information that has informed my decision to be vaccinated.

NorthShore Vaccine Program:

I understand that receiving the vaccine does not eliminate the need to continue following health official guidance on COVID-19 safety practices that will help keep me and other community members safe. I understand and acknowledge that NorthShore will provide me a CDC vaccination record documenting my receipt of the vaccine which is my responsibility to maintain.

If I am an employee or eligible team member of NorthShore, including any of its affiliated organizations listed above, I understand that receipt of the vaccine does not exempt me from following NorthShore's COVID-19 emergency response and preparedness protocols. I acknowledge that I will continue to follow NorthShore's safety practice policies including use of appropriate facemasks and personal protecting equipment, social distancing, hand hygiene, and any other safety practices implemented.

I understand that certain vaccine is administered in two doses and that a vaccine booster, or third dose, is recommended in some cases. I am responsible for following the scheduling instructions I receive in order to return for additional doses and complete my vaccine series or receive a booster. I understand and acknowledge that my failure to adhere to this recommended dosing schedule may impact the efficacy of my vaccine.

NorthShore University HealthSystem

Effective September 2021

I understand that if I have any follow-up questions, concerns or adverse medical reactions to the vaccine, I should contact my physician or other qualified healthcare provider, and that if I am an employee or eligible team member of NorthShore I may seek such care through Employee Health, in which case it will be coordinated through NorthShore providers who will have access to my COVID-19 vaccination record in my EPIC health record. I understand for emergency medical attention including any severe adverse reaction to the vaccine, I should call 911 to access my local emergency services. I understand and acknowledge that I should enroll in VSAFE online at: Vsafe.cdc.gov which provides health checks on individuals who get the vaccine, and that I should report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 or https://vaers.hhs.gov/reportevent.html.

I acknowledge that I have been provided and reviewed an Emergency Use Authorization fact sheet or Vaccine Information Statement, as applicable, about the COVID-19 vaccine which is available at: northshore.org/covidvaccine and understand that NorthShore's COVID-19 vaccination program is following the current guidance from CDC available at cdc.gov and applicable local health officials.

By signing below, I, which includes me/my dependent ("me", "my" or "I" throughout), confirm that I have read, understood and agreed to the contents of this Consent form. I have been able to ask questions, and all of my questions have been answered to my satisfaction and I am choosing to receive a COVID-19 vaccine.

_____ **Signature of Patient (age 18 or older) or Personal Representative** *Relationship to Patient (check one): ____Parent ____ Guardian ____ Legal Representative*	_____ **Date**
_____ **Signature of Minor Patient (age 12 to age 17)**	_____ **Date**
Office Use:	
Lot #:	**Expiration:**
Name of Clinician:	**EID of Clinician:**
MRN:	**Deltoid (Arm): Right ☐ Left ☐**