NorthShore University HealthSystem

Effective January 1, 2021

COVID-19 VACCINE CONSENT FORM
53770-002 (1/2021)

Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	Date of Birth: XXXXXX	Date: XXXXXXXXXXXX

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 and Swedish Hospital 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 which have received an Emergency Use Authorization (EUA) from the U.S. Food and Drug Administration. I understand that because the vaccines are approved through the EUA process, there is limited data available about the short-term (duration of the study trial) safety of the vaccine. This 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. Specifically, I understand and acknowledge that individuals who have had a PCR-confirmed COVID infection in the previous 90 days will not be eligible to receive the vaccine at this time. As such:

I attest, to the best of my knowledge that I have NOT had a COVID-19 infection in the past 90-days.

I attest that I have not and do not plan to receive a non-COVID-19 vaccine in the 14 days before or after either COVID-19 vaccine dose.

Additionally, the Center for Disease Control and Prevention's ("CDC") Advisory Committee on Immunization Practices has provided guidance for vaccination of special populations, including individuals who: (1) are pregnant, (2) currently breastfeeding, (3) have serious allergies, and/or (4) are immunocompromised or taking medications that impact immune response.

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

NorthShore Vaccine Program:

I understand that it is my voluntary decision to receive a COVID-19 vaccine. I understand that receiving the vaccine does not eliminate the need to continue following health official guidance on COVID-19 safety practices including use of appropriate facemasks, social distancing, hand hygiene, and/or travel restrictions among others measures 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 of NorthShore, including any of its affiliated organizations listed above, I acknowledge it is not a condition or requirement of my employment with NorthShore to receive a COVID-19 vaccine and 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, and hand hygiene.

I understand that the vaccine is administered in two doses with Pfizer-BioNTech vaccine doses to be administered 21 days apart and Moderna vaccine doses to be administered 28 days apart and that I am responsible for following the scheduling instructions I receive

in order to return for a second dose and complete my vaccine series. I understand and acknowledge that second vaccine doses administered within a grace period of ≤4 days from the recommended date for the second dose are considered valid. I understand and acknowledge that my failure to adhere to this recommended dosing schedule may impact the efficacy of my vaccine.

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 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 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 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.

Printed Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	**Signature:** XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Office Use:	
Lot #:	**Expiration:**
Name of Clinician:	**EID of Clinician:**
MRN:	**Deltoid (Arm): Right ☐ Left ☐**