TOTALWELLNESS

COVID-19 VACCINE INFORMATION, CONSENT & RELEASE

NURSE'S BOX Event #: _____ Event Date: _____
Injection Site: ☐ Right Arm ☐ Left Arm ☐ Other: _____
Vaccine Dose: ☐ .5 mL ☐ .3 mL **Dose in Series:** ☐ 1st ☐ 2nd
Vaccine Manufacturer: ☐ Moderna ☐ Pfizer ☐ Johnson & Johnson
Lot #: _____ **Nurse Name:** _____

There are common risks associated with the COVID-19 vaccine that include, but are not limited to pain, redness or swelling at the site of injection, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, feeling unwell or swollen lymph nodes (lymphadenopathy). The COVID-19 vaccine may cause a severe allergic reaction, which can include anaphylaxis (difficulty breathing, swelling of the face and throat, a fast heartbeat, a rash all over the body, dizziness and/or weakness). The allergic reactions, which usually occur immediately, are rare but possible in individuals allergic to any vaccine component. These may not be all the side effects of the COVID-19 vaccine as the vaccine is still being studied in clinical trials. It is impossible to predict all possible side effects or complications associated with the vaccine. The long-term side effects or complications of this vaccine are not known at this time. **Note that, although very unlikely, should you have a severe allergic reaction to the COVID-19 shot, epinephrine may be administered and Emergency Medical Services may be called to the scene.** Also, in the rare event that a needle stick injury occurs, you may be contacted about recommended follow up procedures. By providing consent to receive the COVID-19 vaccine, you are likewise providing consent to receive the necessary emergency medical treatment should you develop an immediate severe allergic reaction to the COVID-19 vaccine. If you develop symptoms of an allergic reaction following vaccination, call 911 or go to the nearest Hospital Emergency Department.

SCREENING FOR VACCINATION ELIGIBILITY

Please respond to the following questions to determine eligibility for vaccination. If you do not understand a question, please contact your healthcare provider.

1.	Have you received any other vaccinations in the last 14 days?	YES	NO	
2.	Have you received convalescent plasma or monoclonal/polyclonal antibody infusions for COVID-19 within the past 90 days?	YES	NO	
3.	Have you tested positive for and/or been diagnosed with COVID-19 infection within the last 10 days?	YES	NO	
4.	Have you ever received a COVID-19 vaccination?	YES	NO	
5.	Do you have today or have you had at any time in the last 10 days a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?	YES	NO	
6.	Have you had a severe allergic reaction (e.g. needed epinephrine or hospital care) to any vaccine?	YES	NO	
7.	Have you ever had a severe allergic reaction (e.g. anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?	YES	NO	
8.	If female, are you pregnant or is there a chance you could become pregnant?	YES	NO	N/A
9.	If female, are you currently breastfeeding?	YES	NO	N/A
10.	Have you ever had a reaction to latex?	YES	NO	
11.	Are you immunocompromised or on a medication that affects your immune system?	YES	NO	
12.	Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?	YES	NO	

If you answer yes to question 5, 6, 7, 8, 9, or 10 please consult with your primary care physician prior to receiving a COVID-19 vaccine. Note: answering "yes" does not necessarily mean you should not be vaccinated; it simply means additional questions may need to be asked.

I understand the risks and benefits associated with the vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine and the TotalWellness Privacy Practices Notice. I have carefully reviewed this form and have had the opportunity to ask questions to my satisfaction prior to signing. I recognize that services may be rendered in an area with limited privacy. If I desire greater privacy, I will let my nurse know. I agree to remain at the event for at least 15 minutes after vaccination for supervision. I understand the benefits and risks of the COVID-19 vaccine and hereby consent and request that the vaccine be given to me. I expressly waive, release and forever discharge for myself, my heirs, estate, executors, administrators, successors and assignees, Vaccination Services of America, Inc. d/b/a TotalWellness and its employees, owners and representatives, as well as my employer or any other company involved with this event and their agents, representatives, employees, successors, assignees, governing bodies, and advisory committees (collectively, "Releasees") from any and all claims, demands, actions and causes of action, now known or hereafter known in any jurisdiction throughout the world, on account of injury, death or property damage arising out of or attributable to my participation in this vaccination program, whether arising out of the negligence of TotalWellness or any Releasee or otherwise. I further agree to indemnify, defend and hold harmless the Releasees from any litigation expense, attorney fees, or claim for personal injury in connection with my participation in this vaccination program. I understand that the information collected and entered onto this form may be transferred to TotalWellness via an express carrier (UPS, FedEx, etc.). I consent to the transfer of my immunization data to the Immunization Information Systems and/or any applicable state immunization registry or similar immunization records. I understand that TotalWellness may provide my name/unique ID to the sponsoring company for participation. I will share the information provided about my vaccination with my primary care provider. I further authorize TotalWellness or its agents to submit a claim to my insurance provider for me for the COVID-19 vaccine administration.

Participant First Name: _____ Participant Last Name: _____

Participant Date of Birth: (mm/dd/yyyy) __ / __ / ____ Age ____ Mobile Phone Number: ___ - ___ - ____

Home Address: _____

City: _____ State: ____ Zip Code: _____

Email Address: _____

Race: _____ Ethnicity: _____ Sex: _____

Signature: _____ **Date:** _____

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