**COVID-19 VACCINE**
INFORMATION, CONSENT & RELEASE FORM

**NURSE'S BOX** Event #: ______________ Event Date: ______________
Injection Site: ☐ Right Arm ☐ Left Arm ☐ Other: ______________
Vaccine Dose: ☐ .5 mL ☐ .3 mL
Vaccine Manufacturer: ☐ Moderna ☐ Pfizer ☐ Novavax
Lot #: ______________ Nurse Name: ______________________

There are common risks associated with COVID-19 vaccine such as 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). 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. Allergic reactions, which usually occur immediately, are rare but possible in individuals allergic to any vaccine component. **Should you have a severe allergic reaction to the COVID-19 vaccine, epinephrine may be administered and Emergency Medical Services may be called to the scene.** In the rare event 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 ask the nurse for clarification.

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| 1. | Have you ever received a dose of COVID-19 vaccine?<br>If Yes, when was your last dose: ______________ | YES | NO | |
| 2. | Have you been sick or had a fever above 101°F in the last 3 days? | YES | NO | |
| 3. | Do you have allergies to medications, food, a vaccine component, or latex?<br>If YES, please explain: | YES | NO | |
| 4. | Have you ever had a serious reaction after receiving a vaccine? | YES | NO | |
| 5. | Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19? | YES | NO | |
| 6. | If female, are you pregnant? | YES | NO | N/A |

If you answer yes to question 2, 3, 4, 5, or 6 please consult with your primary care physician prior to receiving a COVID-19 vaccine.

I understand the risks and benefits associated with the vaccine and have received, read and/or had explained to me the current COVID-19 Vaccine Information Statement available at https://www.immunize.org/wp-content/uploads/vis/covid-19.pdf and the TotalWellness Privacy Practices Notice https://www.totalwellnesshealth.com/privacy-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 if this is my first COVID-19 vaccination of if requested by the nurse. 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. I will visit https://www.totalwellnesshealth.com/private/ir-opt-out and complete the applicable state opt out form if I wish to opt out of registry reporting and my state allows this option. 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.

By signing this form, I attest that I am an eligible candidate for the vaccine because I am either 65 years of age or older OR I have a condition* that puts me at high risk for severe outcomes from COVID-19 virus.

**First Name** ______________ **Last Name** ______________

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

**Sex:** (circle) Male Female Prefer not to answer

**Company:** ______________ **City:** ______________ **State:** ______

**Home Address:** ______________________

**Home Address City:** ______________ **State:** ______ **Zip:** ______

**Race:** ______________ **Ethnicity:** ______________

**Signature:** ______________________ **Date:** ______________

*A list of conditions that may put you at high risk for severe outcomes from COVID-19 virus can be found at https://www.cdc.gov/covid/risk-factors/index.html or
**Participant must be a legal adult in the state where the vaccine is being administered.
This form is the property of TotalWellness. The back of this form is intentionally left blank.