HOUSTON HEALTHCARE

ACKNOWLEDGMENT, RELEASE AND CONSENT FOR 2020-2021 COVID-19 VACCINE

I have received a personal copy and reviewed the following information as distributed by the Food and Drug Administration (FDA) with Revision date of _____.

FACT SHEET FOR RECIPIENTS AND CAREGIVERS EMERGENCY USE AUTHORIZATION (EUA) OF THE PFIZER-BIONTECH COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 16 YEARS OF AGE AND OLDER

*****Initial the blanks below*****

____I understand I should not receive the vaccine if:

- I have had a severe reaction to any ingredient of the vaccine identified in the FDA Fact Sheet referenced above
- I experience a severe allergic reaction to the first dose, I should not take a subsequent dose

____I understand the FDA has authorized the emergency use of the COVID-19 vaccine, which is not an FDA-approved vaccine. I have had the chance to ask questions and receive satisfactory answers.

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

____I hereby consent to receive the COVID-19 vaccine at my sole risk. I understand there is no guarantee immunity will result from this immunization.

____I hereby expressly release, indemnify and hold harmless Houston Healthcare, their agents, directors, employees and representatives from any and all responsibility or obligation for any and all adverse effects and/or personal injury (including death) that may occur as a result of receiving this injected vaccine.

Printed Name Date of Birth Employee ID and Department

Signature Time/ Date

Signature of Guardian (If less than 18 years of age) Relationship of Guardian to patient

Witness Signature Printed Name/Title Time/Date

Ethnicity (Circle one)
Hispanic or Latino
Not Hispanic or Latino

Race (Circle one)
American Indian or Alaskan Native
Asian
Native Hawaiian or other Pacific Islander
Black or African American
White
Hispanic or Latino
Other Race

Gender (Circle One)
Male Female

Dose 1

0.3 ml IM injection given in Deltoid: Right ____ Left____ By: _____

VACCINE INFORMATION

Brand Name: Manufacturer: Lot#:_____Expiration Date: _____

Dose 2 (21 days after first dose)

0.3 ml IM injection given in Deltoid: Right ____ Left____ By: _____

VACCINE INFORMATION

Brand Name: Manufacturer: Lot#:_____Expiration Date: _____

HOUSTON MEDICAL CENTER
1601 Watson Blvd.
Warner Robins, GA 31093
(478)922-4281

PERRY HOSPITAL
1120 Morningside Dr.
Perry, GA 31069
(478) 987-3600

www.hhc.org