Central Maine Healthcare

BRIDGTON HOSPITAL • RUMFORD HOSPITAL
CENTRAL MAINE MEDICAL CENTER

2021 COVID-19 Vaccine Consent

PRINT CLEARLY Name: Date of Birth:

Individuals receiving the COVID 19 Vaccine are still required to follow all CDC masking/PPE, hand hygiene and physical distancing recommendations.

Please indicate if any of the following are true. Vaccine may not be indicated depending upon your responses

- Serious or immediate allergic reactions to vaccines, medications or foods? ☐ YES ☐ NO
- Are you currently experiencing any symptom of COVID 19?..... ☐ YES ☐ NO
- Previously received COVID 19 Vaccine?..... ☐ YES ☐ NO
- Received any other vaccine within the last 14 days?..... ☐ YES ☐ NO
- Previously received monoclonal antibodies or convalescent plasma as part of COVID 19 treatment? ..... ☐ YES ☐ NO

Special Note: Please **consult with your primary care provider** prior to obtaining the vaccine if you are immunocompromised, have a bleeding disorder or taking a blood thinner, pregnant, planning to become pregnant or breastfeeding.

- If you are immunocompromised, have a bleeding disorder or taking a blood thinner, pregnant, planning to become pregnant or breast feeding, has your provider advised you to **NOT** receive the vaccine? ..... ☐ YES ☐ NO ☐ N/A

I have read the current FACT SHEET FOR RECIPIENTS AND CAREGIVERS *https://www.cdc.gov/vaccines/covid-19/eua/index.html* ***and I have had a chance to ask questions and any questions were answered to my satisfaction. I understand the benefits and risks of COVID-19 vaccination, and I have chosen to receive the COVID-19 vaccine.***

I understand that I am receiving a vaccine that is administered under an Emergency Use Authorization of the United States Food & Drug Administration. I understand that not all of the possible side effects or complications associated with the vaccine are known at this time.

I acknowledge that I have been advised to remain near the site of vaccination administration for 15 minutes following vaccination. I understand that the COVID 19 Vaccine may require two doses of vaccine 3 WEEKS apart (Pfizer) or 4 WEEKS apart (Moderna). The Janssen vaccine requires a single dose. I understand I may experience mild, moderate or severe symptoms after administration of the vaccine.

I understand that it is not possible to contract COVID 19 from the vaccine, however, if I have already contracted COVID 19 and I am asymptomatic, the vaccine will not prevent disease progression.

I acknowledge that I understand the purpose of the Maine Immunization Registry and the Central Maine Healthcare will disclose required information to the registry for public health purposes. I authorize my COVID Vaccine record to be shared with my primary care physician; and to be used or shared for payment, quality of care, patient safety and research purposes. Otherwise the information will be shared in accordance with the Central Maine Healthcare Notice of Privacy Practices available at https://www.cmhc.org/about-us/cmh-privacy-policy/, with printed copies also available upon request.

I consent to being contacted by Central Maine Healthcare or its agents by telephone (cell or landline), text message, or voice message at the telephone number previously provided. This consent applies to those individuals who are acting on my behalf.

On behalf of myself, my heirs, and personal representatives, I hereby release and hold harmless Central Maine Healthcare and its providers, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liability or claims whether known or unknown arising out of, in connection with or in any way related to the administration of the COVID 19 Vaccine.

X _____ **Today's Date & Time :** _____

(Printed name and signature of Patient (or Authorized Legal Representative)

X_____**Today's Date & Time:** _____

Witness printed name and signature (For phone consent or when patient is physically unable to sign)

Interpreter for: Sign Language Foreign Language Other

Print Name or identifying information: _____