

## **HOUSTON HEALTHCARE**

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

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 NDIVIDUALS 16 YEARS OF AGE AND OLDER
**Initial the blanks below**
I understand I should not receive the vaccine if:
<ul> <li>I have had a severe reaction to any ingredient of the vaccine identified in the FDA Fact Sheet referenced above</li> <li>I experience a severe allergic reaction to the first dose, I should not take a subsequent dose</li> </ul>
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 lirectors, 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 his injected vaccine.

HOUSTON MEDICAL CENTER 1601 Watson Blvd. Warner Robins, GA 31093 (478)922-4281 PERRY HOSPITAL 1120 Morningside Dr. Perry, GA 31069 (478) 987-3600

Printed Name	Date of Birth	Е	Employee ID and Department	
Student Signature			Time/ Date	
Signature of Parent/Guard	lian	Relationship of Guardian to patient		
Witness Signature	Printed Name	/Title	Time/Date	
Ethnicity (Circle one) Hispanic or Latino Not Hispanic or Latino  Gender (Circle One) Male Female  Dose 1  0.3 ml IM injection given	Race (Continue)  American Indian or Alaskan Nation  Native Hawaiian or other Pacific  in Deltoid: Right Left	Islander	Black or African American White Hispanic or Latino Other Race	
VACCINE INFORMATI				
Brand Name:	Manufacturer:	Lot#:	Expiration Date:	
VACCINE INFORMATI	in Deltoid: Right Left			

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