JANSSEN (J&J) COVID-19 VACCINE CONSENT FORM

Name of Recipient (**PLEASE PRINT CLEARLY**)_____

Email_____ Sex: Male Female Date of Birth / / ☐☐☐☐
MM DD YEAR

Address:_____ City:_____ State:_____ Zip Code:_____

Phone Number:_____ County:_____

For ImmTrac2 State Use:

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American ☐ White ☐ Other ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

FOR MEDINA HEALTHCARE SYSTEM EMPLOYEES, PERSONNEL and AFFILIATES ONLY

☐ MHS Employee ☐ External Physician/Medical Contractor/NP/PA ☐ Contractor ☐ Other:

Department_____ Hospital_____ Clinic:_____

I declare that I am 18 years of age or older. I further declare that I:

1. Have not experienced anaphylaxis (difficulty breathing) or severe allergic reactions from a previous vaccination or an injectable medication.
2. Have not had any other vaccinations in the previous 14 days (e.g. MMR, Shingrix, Varicella, or a TB skin test).
3. Am not currently sick with a fever, active respiratory infection or other moderate/severe illness.
4. Have not had COVID-19, received monoclonal antibodies or convalescent plasma for treatment of COVID-19 within the past ninety (90) days.
5. To my knowledge, am not allergic to the following ingredients in the Janssen COVID-19 vaccine: recombinant replication-incompetent adenovirus type 26 expressing the SARS-CoV-2 spike protein, citric acid monohydrate, trisodium citrate dehydrate, ethanol, 2-hydroxyproply-B-cyclodextrin (HBCD), polysorbate-80, sodium chloride.
6. Have not received another COVID-19 vaccine.

I understand that if I have any of the above conditions, I could be at increased risk of having a negative reaction or problem from the vaccine.
I further declare that if I have any of the following conditions, I have had the opportunity to speak with my primary care provider and am making an informed decision to receive the vaccine: have a bleeding disorder or are on a blood thinner, are immunocompromised or are on a medicine that affects your immune system, are pregnant or plan to become pregnant, are breastfeeding.

I agree to WAIT in the vaccine administration location for 15 minutes after receiving the vaccine. If I have previously had a severe allergic reaction to a vaccine or injectable medication, I agree to WAIT in the vaccine administration location for 30 minutes after receiving the vaccine. I understand the Janssen COVID-19 vaccine is a single dose.

I understand that the common risks associated with the COVID-19 vaccine 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). I understand that the 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). I understand that these may not be all the side effects of the COVID-19 vaccine as the vaccine is still being studied in clinical trials. I also understand that it is not possible to predict all possible side effects or complications which could be associated with the vaccine. I understand that the long-term side effects or complications of this vaccine are not known at this time.

I understand that the vaccination is being given by Medina Healthcare System. Medina Healthcare System's officers, directors, employees and agents expressly disclaim any responsibility for the vaccination. My consent is given in light of this knowledge and in consideration of Medina Healthcare System giving the COVID-19 vaccine. I, for myself and my heirs, administrators, trustees, executors, assigns and successors in interest do hereby agree to release and hold harmless Medina Healthcare System, its subsidiaries, divisions, affiliates, successors, assigns, officers, trustees, employees, volunteers and agents from and against any and all demands, damages, losses, costs, expenses, obligations, liabilities, claims, actions and cause of action (whether any of which is groundless or otherwise) of any nature whatsoever (including, without limitation, reasonable attorney's fees and court costs) by reason of or resulting, in any way, from any and all acts, accidents, events, occurrences, omissions and the like related to, or arising out of, directly or indirectly, my receipt of this COVID-19 vaccine. Medina Healthcare System makes no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness for a particular purpose regarding the vaccine or its effectiveness.

I have read and understood "What To Do If You Have A Reaction To The COVID-19 Vaccination" and the "Fact Sheet" by the FDA regarding the COVID-19 Vaccination. I further understand and agree that Medina Healthcare System is required to submit COVID-19 vaccine administration data to the Texas Immunization Information System (VIIS), and report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS).

I understand and agree to all of the above and I hereby give my consent to the staff of Medina Healthcare System to give me a COVID-19 vaccine.

Signature of Patient/Parent:_____ **Date:**_____

Janssen Lot # & Vial Exp.
Lot # _____

Vial Exp. Date_____

Route ☐ IM ☐ RD ☐ LD

Administered by (legal signature and title)

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