Cancer Treatment Centers of America®

Comprehensive Cancer Care Network

COVID-19 VACCINE ADMINISTRATION RECORD & CONSENT FORM

Name (Print) _____ **Date of Birth** _____

Address _____ **City** _____

State, Zip _____ **Telephone** _____

COVID-19 IMMUNIZATION SCREENING QUESTIONS

1.	In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19?	☐ Yes ☐ No
2.	In the past two weeks, have you had known contact with anyone who has tested positive for COVID-19 or have you been instructed to quarantine?	☐ Yes ☐ No
3.	Do you currently have the new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	☐ Yes ☐ No
4.	Have you been administered any other vaccine within the past 14 days?	☐ Yes ☐ No
5.	***[Only answer this question if you have already received a COVID-19 vaccine dose]*** After your last COVID-19 vaccine dose, did you experience anaphylaxis, itching, swelling or respiratory distress within 4 hours of vaccine administration?	☐ Yes ☐ No

If you answered "Yes" to any of questions 1 – 5, the COVID-19 vaccine cannot be administered at this time.

6.	Are you sick today? (For example: cold, fever, or acute illness)	☐ Yes ☐ No
7.	Have you ever experienced a severe allergic reaction to something, including chemotherapy-related medications? (For example, a reaction for which you were treated with epinephrine)	☐ Yes ☐ No
8.	Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	☐ Yes ☐ No
9.	***[Only answer this question if you have already received a COVID-19 vaccine dose]*** Have your answers to any of the above questions changed since your last dose?	☐ Yes ☐ No

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CONSENTS & ACKNOWLEDGEMENT

By my signature below, I acknowledge and consent as follows:

- I understand that COVID-19 is a contagious viral infection of the respiratory tract that can spread from person to person usually through close contact with an infected person or through respiratory droplets that are dispersed into the air when an infected person coughs, sneezes, talks, or sings. Droplets can land in the mouths or noses of people who may be close by. Spread is more likely when people are within 6 feet of distance of each other. Infection may also occur when a person comes in contact with a surface contaminated by the referenced droplets.

- I understand that as of the date of this of this consent, vaccination is expected to be among the most effective means of slowing the spread of the COVID-19 infection and ending the ongoing global pandemic. Further, I understand the vaccine is intended as a two-shot series to maximize efficacy. The second vaccine administration must be given approximately 21 or 28 days (depending on the specific vaccine administered) after the initial administration. I also understand that between the first and second administrations of the COVID-19 vaccine, I should not have any other vaccines administered.

- I have received a copy of the COVID-19 vaccine Fact Sheet for Recipients and Caregivers and been given an opportunity to review it prior to vaccine administration. I may also access such vaccine fact sheet online through the U.S. Food and Drug Administration at:

  www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines

  I acknowledge that such fact sheets, among other things, provide the following:

  - The FDA has authorized the emergency use of the COVID-19 Vaccine
  - The significant known and potential risks and benefits of the COVID-19 Vaccine, and the extent to which such risks and benefits are unknown
  - Information about available alternative vaccines and the risks and benefits of those alternatives

- I understand that the COVID-19 vaccine, like all medicines, can cause side effects. Most side effects are mild and short-term and not everyone experiences them. Based on recent CDC guidance, I understand that anaphylaxis, itching, swelling or respiratory distress within 4 hours of COVID-19 vaccine administration, is a contraindication for receiving a future dose of the COVID-19 vaccine. CDC guidance also states that a second vaccine should only be considered after an evaluation by an allergist-immunologist who would determine if I can safely receive the second vaccine. If I experience severe side effects, I should immediately call 9-1-1 or seek medical attention. Further, I understand that severe side effects may have to be reported to relevant regulatory authorities, and as such, I will report all severe side effects to CTCA as the entity who administered my vaccine.

- I understand that the COVID-19 vaccine is a two-part vaccine series. By signing this consent, I am agreeing that I will receive the first and second part of the vaccine series.

REQUIRED INFORMATION (CHOOSE THE BEST AVAILABLE OPTION):

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African-American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other race
- ☐ White
- ☐ Unknown

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

I have read and understand each of the above consents. Through my signature below, I voluntarily and without coercion assume full responsibility for my decision to have the COVID-19 vaccine administered and knowingly accept full responsibility for any reactions that may result. I release and hold my vaccine administrator, Cancer Treatment Centers of America and its affiliated entities, harmless 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, for its actions administering the COVID-19 vaccine. Cancer Treatment Centers of America and its affiliated entities make 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.

Signature _____ **Date** _____

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Second Administration Acknowledgement

Through my signature below, I confirm that my answers to the COVID-19 Immunization Screening Questions are unchanged as of the date of the second vaccine administration. I voluntarily and without coercion assume full responsibility for my decision to receive the second administration of the COVID-19 vaccine. I release and hold my vaccine administrator, Cancer Treatment Centers of America and its affiliated entities, harmless 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, for its actions administering the COVID-19 vaccine. Cancer Treatment Centers of America and its affiliated entities make 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.

Signature _____ **Date** _____

TO BE COMPLETED BY STAKEHOLDER/OCCUPATIONAL HEALTH REPRESENTATIVE

1st Administration

Vaccine Manuf. _____ Lot # _____ Exp. Date _____

Route: IM Deltoid: Left Right

Administered By: _____ Administration Date: _____

2nd Administration

Vaccine Manuf. _____ Lot # _____ Exp. Date _____

Route: IM Deltoid: Left Right

Administered By: _____ Administration Date: _____

_____

Name (print)