EMPLOYEE COVID CONSENT FORM

I. EMPLOYEE INFORMATION

Employee Name: _____

Date of Birth: _____ Telephone: _____

Address: _____

II. ELIGIBILITY

1. Have you received the COVID-19 vaccine? ☐ Yes ☐ No
2. Are you 18 years of age or older? ☐ Yes ☐ No
3. Have you ever had a severe allergic reaction? ☐ Yes ☐ No
4. Are you allergic to any component of the COVID-19 Vaccine (mRNA, salts, fats, or sugars)? ☐ Yes ☐ No
5. Have you received monoclonal antibody treatment for COVID-19, or convalescent plasma, in the last 90 days? ☐ Yes ☐ No

III. CONSENT

I understand I will receive the Emergency Use Authorization Fact Sheet or Vaccine Information Statement (VIS).

☐ **I CONSENT** to administration of the COVID-19 vaccine. I have been informed of the method of administration, the risks, complications and expected benefits of the vaccine.

☐ **I DO NOT CONSENT** to administration of the COVID-19 vaccine. I understand that by declining this vaccine, I continue to be at risk of acquiring COVID-19, a serious disease, which could result in life-threatening consequences to my health and the health of the residents in this healthcare facility, my coworkers, my family and my community.

Signature: _____ Date: _____