MERCYHEALTH

Attestation for Administration of COVID-19 Vaccine Per Emergency Use Authorization

Full Legal Name: _____ Date of Birth _____Age _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Are you feeling sick today? ❑ Yes ❑ No ❑ Don't Know
2. Have you ever received a dose of COVID-19 Vaccine? ❑ Yes ❑ No ❑ Don't Know

   If yes, which vaccine product? ❑ Pfizer ❑ Moderna ❑ Another product (noted on your vaccine card)
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction the occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)
   a. A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures ❑ Yes ❑ No ❑ Don't Know
   b. Polysorbate ❑ Yes ❑ No ❑ Don't Know
   c. A previous dose of COVID-19 vaccine ❑ Yes ❑ No ❑ Don't Know
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction (e.g., anaphylaxis) that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) ❑ Yes ❑ No ❑ Don't Know
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies. ❑ Yes ❑ No ❑ Don't Know
6. Have you received any vaccine in the last 14 days? ❑ Yes ❑ No ❑ Don't Know
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? ❑ Yes ❑ No ❑ Don't Know
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? ❑ Yes ❑ No ❑ Don't Know
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? ❑ Yes ❑ No ❑ Don't Know
10. Do you have a bleeding disorder or are you taking a blood thinner? ❑ Yes ❑ No ❑ Don't Know
11. Are you pregnant or breastfeeding? If yes, please circle which one(s) ❑ Yes ❑ No ❑ Don't Know

I understand that the COVID-19 vaccine I am receiving is being administered to me pursuant to a U.S. Food and Drug Administration Emergency Use Authorization (EUA). I (or my legal surrogate decision maker) have received and read the EUA Fact Sheet for recipients of this vaccine, which fully explains to me the risks and benefits of receiving this vaccine. I agree that Mercy Health has not made any guarantees to me about the result(s) of this vaccination, and I understand that I may experience side effect(s) after receiving this vaccine. I acknowledge that I have been advised to remain near the vaccination location for at least 15 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital. **I further understand that this vaccine may be administered as a 2-dose series, and I agree that I will promptly schedule my second-dose appointment. I agree that it is my personal decision to receive this EUA COVID-19 vaccine, and I give Mercy Health permission to administer this vaccine to me. By signing below, I further confirm that**: I have read this Attestation or had it effectively communicated to me; any questions I may have had about it or the vaccine document(s) provided to me by Mercy Health have been answered to my satisfaction; I understand and accept all terms of this Attestation; I am the individual identified, above, or his/her authorized personal representative; I am at least 18 years of age; and that I have signed this Attestation voluntarily.

Signature: _____Date: _____

Parent/Legal Guardian _____