HaysMed

JANSSEN COVID-19 VACCINE CONSENT/DOCUMENTATION FORM

First Name: _____Last Name: _____ Date of Birth: _____ Male

Primary Race: _____ Not Hispanic Address: _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

You are being offered the JANSSEN COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2. The JANSSEN COVID-19 Vaccine may prevent you from getting COVID-19. The JANSSEN COVID-19 Vaccine is administered as a SINGLE SHOT, into the muscle. The JANSSEN COVID-19 Vaccine may not protect everyone. The following questions will help us determine if you may receive the JANSSEN COVID-19 vaccine. Please mark YES or NO for each question.

1) Have you ever had an allergic reaction to a vaccine? ○ YES ○ NO
2) Do you have a fever? ○ YES ○ NO
3) Do you have a bleeding disorder or are on a blood thinner? ○ YES ○ NO
4) Are you immunocompromised or are on a medicine that affects your immune system? ○ YES ○ NO
5) Are you pregnant or plan to become pregnant? ○ YES ○ NO
6) Are you breastfeeding? ○ YES ○ NO
7) Have you previously received any type of COVID vaccine? ○ YES ○ NO

YOU SHOULD <u>NOT</u> GET THE JANSSEN COVID-19 VACCINE IF YOU:

- had a severe allergic reaction after a previous dose of this vaccine
- had a severe allergic reaction to any ingredient of this vaccine
- have received intravenous monoclonal antibodies for treatment of COVID in the last three months
- <u>had any other vaccine within the past two weeks</u>

There is a remote chance that the JANSSEN COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the JANSSEN COVID-19 Vaccine. For this reason, **you are required to stay at the clinic for 15 minutes post vaccination for monitoring** (30 minutes if history of anaphylaxis) as per CDC vaccination guidelines.

Consent for the JANSSEN COVID-19 Vaccine, depending on the response to the above questionnaire: I have been given the FDA/CDC Vaccine Information Statement. I have read this document and have no further questions at this time. I understand the risks and benefits of the vaccine. I request and voluntarily consent that the vaccine be administered to me and I acknowledge that no guarantees have been made concerning the vaccine's success. I hold harmless HaysMed/ECHD and individuals administering the vaccine. I understand the side effects and warnings of the vaccine.

_____ ____4/10/21_____

Patient Signature PRINT FORM CLEAR FORM Date

FOR ADMINISTRATIVE USE ONLY

Vaccination Date: ___4/10/21_____ Administered By, **<u>Print Name</u>**: _____

Lot Number: _____041A21A_____ Expiration Date: __4/10/21____ Vaccine Manufacturer: ____JANSSEN_____

Dosage Amount: __0.5mL_IM_ Clinic ID: _____ Site: __R___L__DELTOID__ 03/2021

Single Dose Vaccine