Delivery Network/Location

NAME:

BIRTH DATE:

MRN:

DOS:

(If handwritten, patient name, MRN, birth date, and DOS)

Yale New Haven Health

Consent for COVID-19 Vaccination

I have read or someone has read to me the 2020-2021 Vaccine Information Statement for the Covid-19 vaccine. I understand the risks and benefits of the vaccine and I voluntarily assume responsibility for any reactions that may result from receipt of the vaccine. I have had an opportunity to ask questions regarding the vaccine and all of my questions have been answered to my satisfaction.

I understand that the Covid-19 vaccine is a two-part vaccine series. I consent to the administration of the first and second part of the vaccine on behalf of myself or the person named below for whom I am the parent or legal guardian ("Ward").

After the administration of the first part of the vaccine, if I or my Ward suffers a reaction to the vaccine that is sudden or severe, I will consult with a medical provider before receiving the second part of the vaccination series.

I, for myself or on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release Yale New Haven Health, its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or, in any way related to my receipt and the receipt of my Ward of this or these vaccines(s). Neither the provisioning vaccination center nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccine(s) described above.

My medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. Yale New Haven Health may use and disclose the personal and health information of myself or my Ward in order to provide treatment, receive payment for the care provided or for other healthcare operations. I acknowledge that I have received a copy of the Yale New Haven Health Notice of Privacy Practices.

Relationship to patient: _____

Time	Date	Signature	Printed Name
_____	_____	_____	_____

Interpretation Services (if necessary): An interpreter facilitated the communication between the health care provider(s) and the patient or person authorized to consent for the patient in _____ (language) to assist in obtaining informed consent.

The interpreter conveyed the content of the original information expressed by and for both parties.

Time: _____ AM/PM Date: _____

Check here if: ☐ Telephone ☐ Video Interpreter ☐ Interpreter **ID Number** (telephone/video only): _____

Print Name of Interpreter	**Signature Interpreter (face to face only)**
_____	_____