COVID-19 VACCINE CONSENT AND ACKNOWLEDGEMENT FORM

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- I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of a minor patient who is eligible to receive a vaccine; or (c) authorized to consent for vaccination for the patient named below. Further, I hereby give my consent to the Texas Department of State Health Services (TxDSHS), or University of Texas Health Science Center at San Antonio (also known as UT Health San Antonio), or their agents to administer the COVID-19 vaccine.

- I understand that this product has not been approved or licensed by the U.S. Food and Drug Administration (FDA), but has been authorized for emergency use by FDA, under a the Moderna Emergency Use Authorization (EUA) to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older, and under the Pfizer EUA for use in individuals 16 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.

- I understand that it is not possible to predict all possible side effects or complications associated with receiving the vaccine(s). I understand the risks and benefits associated with the vaccine and have received, read and/or had explained to me the Emergency Use Authorization (EUA) Fact Sheet on the COVID-19 vaccine that I am to receive at UT Health San Antonio. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I understand that the brand of COVID-19 vaccination I receive will be based upon availably at the UT Health San Antonio site administering the vaccine. I have also been provided links to the currently available COVID-19 vaccine EUA fact sheets; this list may change based upon authorization and availability.

  - PFIZER-BIONTECH COVID-19 VACCINE EUA
  - MODERNA COVID-19 VACCINE EUA

- I also understand the need for continued masking/social distancing after receiving the COVID-19 vaccination.

- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation and possibly up to 30 minutes if medical provider deems necessary.

- If I experience a severe allergic reaction, I will call 9-1-1, or go to the nearest hospital. Otherwise, if I have any side effects that are bothersome or do not go away, I will contact my primary care physician, healthcare provider or an urgent care center.

- I will report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS). The VAERS toll-free number is 1-800-822-7967 or report online to https://vaers.hhs.gov/reportevent.html.

- UT Health San Antonio advised me to consult with my medical provider to discuss my personal risks, benefits, and potential side effects of receiving the COVID-19 vaccination.

- I voluntarily elect to receive the COVID-19 vaccination at UT Health San Antonio after carefully considering the risks and benefits.

- I acknowledge that UT Health San Antonio has provided me with a completed COVID-19 vaccination card and/or a vaccination record located in MyChart.

- I acknowledge receipt of the UT Health San Antonio Notice of Privacy Practices (NPP). I understand that a copy of the NPP is available to me at the time of vaccination, upon my request, or by visiting: https://uthscsa.edu/hipaa/patientrights/Privacy-Practices-Trifold.pdf.

- Disclosure of your Social Security Number (SSN) is requested from you for UT Health San Antonio to facilitate positive patient identification. It is also required of you for UT Health San Antonio to bill and collect for patient services, such as the vaccine administration fee. Federal law mandates a social security number is required to obtain benefits under Medicare and Medicaid (42 USC, Section 1320b-7(1)). For commercial insurance, there is no statute or authority that requires that you disclose your SSN for this purpose. Failure to provide your SSN, however, may result in us not filing claims for your patient care because commercial insurance requires a SSN.

- Vaccines have already been paid for by the federal government with taxpayers' money, so officials have said the vaccines will be free. UT Health San Antonio may and will charge an administration fee, which will be covered by your health insurance or the CARES Act for patients without insurance. I understand and agree to provide my health insurance information including if I am a Medicare or Medicare Advantage member, and my Medicare Beneficiary Identification (MBI) number.

- I understand that the Centers for Disease Control (CDC) requires that COVID-19 vaccinations given at UT Health San Antonio be tracked and reported to ImmTrac2, the Texas immunization registry, and as otherwise required by the local, state and federal government. Texas Department of State Health Services (DSHS) offers the ImmTrac2 Texas Immunization Registry at no cost to all Texans. The registry is secure and confidential, and safely consolidates and stores immunization records in one centralized system. I acknowledge that: (a) I understand the purposes/benefits of ImmTrac2, Texas immunization registry, and (b) as required by the CDC, UT Health San Antonio will include my personal immunization information and potentially my social security number in the ImmTrac2 registry, which will be shared with the CDC or other federal agencies.

- Research: An important part of our mission is research. At times, we may use or release health information about you related to the COVID-19 vaccine you received at UT Health San Antonio for research purposes. However, all research projects require a special approval process before they begin. In some instances, your health information may be used or released for a research purpose without your authorization in accordance with law. Our researchers may use your health information to identify and contact you as a potential study participant.

I have read the above document and understand its contents. I acknowledge that I am the patient, or I am the patient's legally authorized representative, and or guarantor and consent to the above items and make the acknowledgements hereby made. For questions, contact the Institutional Compliance and Privacy Office at 210-567-2014.

Patient Name: ______________________________ Date: ______________
PRINT

Signature of Patient or Legal Guardian: ______________________________ Date: ______________

Relationship to Patient: ______________________________