RESIDENT CONSENT FOR COVID-19 VACCINATION

The undersigned Resident/POA has read, understands, and agrees to the following:

1. COVID-19 is a potentially deadly disease caused by a novel coronavirus. Symptoms of COVID-19 may include fever, cough, fatigue, loss of taste or smell, nasal congestion, conjunctivitis, sore throat, headache, muscle, and joint pain, skin rash, nausea and vomiting, diarrhea, chills, dizziness, shortness of breath, loss of appetite, confusion, persistent pain or pressure in the chest. While some people who contract COVID-19 experience only mild symptoms, many among those who develop symptoms experience severe illness and/or death. Severe illness may include respiratory failure, acute respiratory distress, sepsis and septic shock, thromboembolism, and multiorgan failure. COVID-19 is highly contagious and has caused a global pandemic.

2. Severe illness, hospitalization, and death from COVID-19 more commonly occur in people aged 60 years and over and those with underlying medical problems like high blood pressure, heart and lung problems, diabetes, obesity, or cancer.

3. A vaccine for COVID-19 has been approved for use by the FDA. This means that the FDA has determined that the known and potential benefits of the vaccine outweigh its known and potential risks and that the vaccine may be effective in preventing COVID-19. The undersigned understands that the COVID-19 vaccine will likely not be 100% effective in preventing COVID-19, and individuals who have been vaccinated should continue to exercise precautions recommended by local, state, and federal health authorities. It is also unknown whether the vaccine will be effective long-term. Even if an individual has received the vaccine, it may still be possible to contract COVID-19.

4. The COVID-19 vaccine will require two doses, administered three weeks apart. By signing this consent, I am agreeing to both administrations of the vaccine. Common side-effects of the COVID-19 vaccine are usually mild and may include muscle soreness, pain, headaches, fever, and body aches. The long-term effects, as well as the long-term effectiveness, are unknown.

I have accepted and read a copy of the information sheet for the COVID-19 vaccine, as well as the information contained above. I have been given the opportunity to ask questions, and any questions were answered to my satisfaction. I understand that I am not required to accept the vaccine. The facility has explained the benefits and risks of the vaccine in a manner that I understand, and I authorize the facility or its designee to administer the vaccine. I will immediately report any adverse reaction to facility staff.

Please check one option below:

_____ I have read this consent form, and **I CONSENT** to administration of the vaccine.

_____ I have read this consent form, and **I REFUSE** the vaccine.

_____ Date:_____

Signature of Individual or Individual's Legal Representative

_____

Printed Name

Witness: I witnessed the above signature of Participant:

Signature:_____ Date:_____