Edward-Elmhurst HEALTHCARE | Healthy Driven

EEH COVID Vaccine Consent (Novavax)

NAME:_____ **DOB:** ____/____/____

STREET ADDRESS:_____

CITY/ STATE: _____**PHONE:**_____

Are you an Edward-Elmhurst Employee? _____ **Employee ID Number:** _____

Manufacturer: Novavax	**Yes**	**No**	**Don't Know**
Screening			
1. Do you currently have any symptoms of COVID, or any other illness, such as **fever**, cough, shortness of breath, sore throat, nausea, or diarrhea?			
2. In the past 90 days, have you tested positive for COVID-19?			
3. **IF #2 IS YES:** Were you diagnosed with Multisystem Inflammatory Syndrome?			
4. In the past 2 weeks, have you been in contact with anyone who tested positive for COVID-19?			
5. Have you ever had a reaction or fainted following a previous vaccine or injectable, including for COVID-19?			
6. Do you have a bleeding disorder or are you on a blood thinner?			
7. Have you received another dose of any COVID-19 vaccine? If yes: Date_____ Brand_____ Date_____ Brand_____			
8. Are you pregnant or breastfeeding, or do you plan to become pregnant?			

I give my permission to Edward-Elmhurst Health, on behalf of its affiliates providing healthcare services (e.g., Edward Hospital, Elmhurst Hospital, Linden Oaks Hospital, Edward Health Ventures) ("EEH") to administer the COVID-19 Vaccine to me. I understand that EEH relies on the health information provided by me above in administering the Vaccination. I understand that EEH, its employees, and physicians are not responsible for any negative effects of the vaccination due to inaccurate or incomplete information provided by me**.** I understand that receipt of this vaccine requires I opt in to the Illinois Comprehensive Automated Immunization Registry Exchange (ICare). The Centers for Disease Control and Prevention (CDC) recommends patients receive the same brand of booster as their original vaccine (series) unless that brand of vaccine is not available, or the patient has a medical preference. ***I certify that I have read, understand, and have been provided a copy of the current Emergency Use Authorization and/or Information Sheet for this vaccine which explains the purpose, side effects, and possible complications of this vaccine and that after review of such documents, I consent to the administration of the COVID-19 Vaccine.***

Patient/ Guardian Signature _____ **Date** _____