COVID-19 VACCINE REGISTRATION AND CONSENT FORM

Township of Hamilton Division of Health
2100 Greenwood Ave, Hamilton, NJ 08609

OFFICIAL USE ONLY

Vaccine:_____

Dose:_____

Public Health
Prevent. Promote. Protect.

Please print clearly

NAME (last, first)			
STREET	EMAIL		
CITY	STATE	ZIP	
PHONE	DATE OF BIRTH	AGE	
GENDER	RACE	ETHNICITY (circle one) Hispanic or Latino	Non-Hispanic
MEDICARE Part B #	Health Insurance Company: Group # ID #		

Please Answer The Following Questions:	**Yes**	**No**	HTHD
1. Is the person to be vaccinated sick today?			
2. Has the person to be vaccinated previously received a dose of COVID-19 vaccine? If yes, date of last vaccination and which vaccine product did you receive? **Date Rec'd**:_____ **Manufacturer/Brand**: _____			
3. Has the person to be vaccinated ever had a severe allergic reaction (e.g. anaphylaxis) to something? For example, being treated with epinephrine/EpiPen or needing to go to the hospital			
a. Was the severe allergic reaction after receiving a COVID-19 vaccine?			
b. Was the severe allergic reaction after receiving another vaccine or another injectable medication?			
4. Does the person to be vaccinated have a bleeding disorder or on blood thinners?			
5. Has the person to be vaccinated received passive antibodies therapy as a treatment for COVID-19?			

- **I** (or the individual on whose behalf I am signing) **have read or had explained to me by the Township of Hamilton Division of Health (HTHD) staff** the attached information about COVID-19 and the COVID-19 vaccine. I (or the individual on whose behalf I am signing) had an opportunity to ask questions about COVID-19 and the vaccine which were answered to my satisfaction, and I (and the individual on whose behalf I am signing) am 18 years of age or older. I have been informed of the Notice of Privacy Practices. If signing on behalf of someone else, I am authorized to sign on that individual's behalf.
- I (or the individual on whose behalf I am signing) am not allergic to Epinephrine (adrenalin) the drug used to counteract an allergic reaction to a COVID-19 vaccine. I (or the individual on whose behalf I am signing) am not allergic to latex. I (or the individual on whose behalf I am signing) do not currently have a fever or the symptoms of an acute infection.
- I (or the individual on whose behalf I am signing) understand that the COVID-19 immunization is administered in a series as currently recommended by the CDC's Advisory Committee on Immunization Practices (ACIP), I (or the individual on whose behalf I am signing) understand that receipt of the vaccine does not completely protect me (or the individual on whose behalf I am signing) against COVID-19 or other illnesses that resemble COVID-19. I (or the individual on whose behalf I am signing) further understand that if I (or the individual on whose behalf I am signing) have a condition of (or am undergoing treatment which causes) immune-suppression (the reduction in my body's ability to fight infection and illness), the effectiveness of the vaccine in prevention COVID-19 may be diminished. I (or the individual on whose behalf I am signing) believe I understand the risks and benefits of the vaccine.
- I (or the individual on whose behalf I am signing) understand that the vaccinated individual will be enrolled in the New Jersey Immunization Information System (NJIIS) pursuant to State of New Jersey Executive Order #207.
- **I (or the individual on whose behalf I am signing) understand that it is my responsibility to remain in the vaccination area for 15 minutes after I (or the individual on whose behalf I am signing) receive the vaccine, in case I (or the individual on whose behalf I am signing) experience a reaction.**
- I (or the individual on whose behalf I am signing) agree to receive the COVID-19 vaccine, and I (or the individual on whose behalf I am signing) hereby release **the Township of Hamilton, Division of Health, and their employees, servants, representatives, officers, and agents (together, the "Indemnitees")** from any liability for giving me (or the individual on whose behalf I am signing) the COVID-19 vaccination. I (or the individual on whose behalf I am signing) agree to indemnify, defend, and hold the indemnities harmless from any claim made by any person, (including the individual on whose behalf I am signing). If Medicare Part B eligible, or other insurance is provided, I (or the individual on whose behalf I am signing) authorized HTHD to bill Medicare Part B or other insurance for the immunization and I (or the individual on whose behalf I am signing) authorize Medicare or other insurance benefits to be paid directly to HTHD.
- **My signature (or the individual's signature on whose behalf I am signing) on this form means that all of the information provided in the Registration and Consent Form are true to the best of my knowledge. I (or the individual on whose behalf I am signing) understand that this form and my signature below are binding on me and my heirs, successors, and personal and legal representatives as well as those of the person on whose behalf I am signing. If I am not the person being vaccinated. I warrant that I have the authority to give this consent for the person to be vaccinated.**

Signature: _____ **Date**: _____

Relationship to person to be vaccinated (circle one): SELF PARENT GUARDIAN MEDICAL POWER OF ATTORNEY

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Vaccination Site: ☐ Right Deltoid ☐ Left Deltoid

Manufacturer:
Lot Number:
Expiration Date:

Clinic Location: _____ **EUA FS Publication Date**: _____ **Date Given**: _____

Vaccine Administered By: _____ **Date**: _____