

CONSENT TO RECEIVE A COVID-19 VACCINATION

The COVID-19 vaccine will be provided at no charge.

I agree that the person named below will receive a COVID-19 vaccine.

I understand that I will not be asked my immigration status as part of the process of receiving the COVID-19 vaccine.

I have been informed and I am aware that a COVID-19 vaccine fact sheet can be found at the following link:

- Moderna COVID-19 Vaccine (PDF) - <https://www.fda.gov/media/144638/download>
- Pfizer COVID-19 Vaccine (PDF) - <https://www.fda.gov/media/144414/download>

V-Safe is a smartphone-based tool for individuals who have received a COVID-19 vaccination. V-safe provides personalized health check-ins by text messages and web surveys. I have been informed that an V-Safe information sheet can be found at the following link:

https://dshs.texas.gov/immunize/covid19/vsafe_info_sheet.pdf.

I know and understand the risks of the COVID-19 disease that this vaccine is meant to prevent, which is predominantly a respiratory illness that can affect other organs.

People with COVID-19 may exhibit symptoms that include but are not limited to:

- fever or chills
- cough;
- shortness of breath;
- fatigue;
- muscle or body aches;
- headache;
- new loss of taste or smell;
- sore throat;
- congestion or runny nose;
- nausea or vomiting; and
- diarrhea.

I know and understand the benefits of receiving a COVID-19 vaccine, which include the prevention of COVID-19, but the duration of protection against COVID-19 using this vaccine is currently unknown and I should continue to stay home if possible, maintain social distance, and wear a mask.

I know and understand the risks of the COVID-19 vaccine, which include but are not limited to:

- injection site pain;
- fatigue;
- headache;
- muscle pain;
- chills;

- joint pain;
- fever;
- injection site swelling;
- injection site redness;
- nausea;
- feeling unwell;
- vomiting; and
- swollen lymph nodes.

I understand the COVID-19 vaccine can also cause severe allergic reactions, which include but are not limited to:

- difficulty breathing;
- swelling of the face and throat;
- a fast heartbeat;
- a bad rash all over the body; and
- dizziness and weakness.

I understand that if I experience a severe allergic reaction, I am advised to call 9-1-1 or seek assistance from the nearest hospital immediately.

I understand that the risks and severe allergic reactions listed in this document and any other information I am provided by the City of Austin may not be all the side effects of the COVID-19 vaccine and that it is not possible to predict all possible side effects or complications associated with the vaccine. I also understand that the long-term side effects or complications of this vaccine are still currently unknown.

I understand that my vaccine information will be sent to ImmTrac2: The Texas Immunization Registry (ImmTrac2). ImmTrac2 is a free service of the Texas Department of State Health Services (DSHS). ImmTrac2 is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). In addition to my agreement and consent below, I GRANT consent for registration and wish to INCLUDE my information in the Texas immunization registry.

<https://www.dshs.texas.gov/immunize/ImmTrac/>

If providing consent for a minor: I understand that by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in ImmTrac2. Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their jurisdiction;
- a physician or other health-care provider legally authorized to administer vaccines for the purpose of treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled; or

- a payor currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that at any time, I may withdraw my consent to have information about myself or my child included in or released from the ImmTrac2 Registry by submitting a written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347. <https://www.dshs.texas.gov/immunize/ImmTrac/>

I understand my participation in this process and any records developed as a result of my participation that could be used to identify me are confidential, not public information, and will be maintained and used for the sole purpose of furthering the City of Austin’s provision of public health services and in accordance with all relevant laws.

City of Austin makes no warranties, express or implied, including but not limited to, implied warranties of merchantability or fitness for a particular purpose regarding the COVID-19 vaccine or its effectiveness.

The City of Austin, their affiliates, officers, directors, employees and agents expressly disclaim any responsibility for the vaccination. My consent is given in light of this knowledge, and in consideration of the City of Austin administering the COVID-19 vaccine.

I AGREE TO HOLD HARMLESS THE CITY OF AUSTIN, INCLUDING ITS EMPLOYEES, AGENTS, AND CONTRACTORS FROM ANY AND ALL LIABILITY AND CLAIMS RELATED TO MY RECEIPT OF THE COVID -19 VACCINE.

I have had a chance to ask questions about the COVID-19 disease, the COVID-19 vaccine, how the COVID-19 vaccine is given, and the risks associated with the COVID-19 vaccine.

I know that the person named below will have the COVID-19 vaccine injected into their body to prevent the COVID-19 disease that the COVID-19 vaccine is meant to prevent.

I am an adult who can legally consent for the person named below to receive the COVID-19 vaccine. I freely and voluntarily give my signed consent and permission for the administration and injection of the COVID-19 vaccine into my person.

By selecting I agree on the "I agree" field when completing this section of the Austin Public Testing Enrollment Form, I acknowledge that I have read, understand, agree, certify, and/or authorize the information above.

Type your full name here _____

{TODAYS} date/time

I AGREE [check box]