UCONN HEALTH

Consent for Administration of COVID-19 Vaccine by UConn Health

I have read or had explained to me the 2020-2021 Vaccine Information Statement for the COVID-19 vaccine and understand the risks and benefits. Furthermore, I have also had an opportunity to ask questions about these immunizations. I believe the benefits outweigh the risks and I voluntarily assume full responsibility for any reactions that may result from either my receipt of the immunization(s) or the receipt of the immunization(s) by the person named below ("Ward") for whom I am the legal guardian and/or legal medical decision-maker. My medical record may be shared with my physician or other healthcare provider and the medical record of my Ward may be shared with his/her physician or other healthcare provider. I am requesting that the immunization(s) be given to me or my Ward. I, for myself and on behalf of my Ward, and each of our respective heirs, executors, personal representatives and assigns, hereby release UConn Health (which is the provisioning mass vaccination center), and its affiliates, subsidiaries, divisions, directors, contractors, agents and employees (collectively "Released Parties"), from any and all claims arising out of, in connection with or in any way related to my receipt and the receipt by my Ward of this or these immunization(s). Neither UConn Health nor any of the Released Parties shall, at any time or to any extent whatsoever, be liable, responsible, or any way accountable for any loss, injury, death, or damage suffered or sustained by any person at any time in connection with or as a result of this vaccine program or the administration of the vaccine(s) described above. UConn Health will use and disclose your personal and health information or the personal and health information of your Ward, to treat you or your Ward, to receive payment of the care we provide, and for other healthcare operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to you and/or your Ward's personal health information.

_____

Printed Name of Patient/Ward

_____

Printed Name of Legal Medical Decision-maker (if not Patient)

_____

Signature of Patient or Legal Medical Decision-maker

_____

Date

Relationship of Legal Medical Decision-maker to Patient/Ward (if applicable):

- ☐ Parent of Minor Child
- ☐ Next of Kin of Adult Patient (specify relationship): _____
- ☐ Health Care Representative appointed by Patient
- ☐ Legal Guardian or Conservator of Person
- ☐ Other (please specify): _____