RANA-REAGAN PHARMACY
398 W Army Trail Rd., Bloomingdale, IL 60108
Phone: 847.610.5169

Last Name: _____ First Name: _____

Date of Birth: _____/_____ /_____ Phone Number: (_____) _____-_____

HOME Address: _____

City: _____ State: _____ Zip: _____

VOLUNTARY 2nd DOSE CONSENT TO COVID-19 VACCINE:

• I understand that COVID-19 can have serious, life-threatening complications (https://www.cdc.gov/coronavirus/2019- ncov/symptoms-testing/symptoms.html), and there is no way to know how COVID-19 will affect me. I further understand that a COVID-19 vaccine may help keep me from becoming seriously ill, even if I do become infected with COVID-19. I have reviewed my specific vaccine EUA Fact Sheet or have had its contents including the benefits, the usual and most frequent risks of receiving this vaccine, and alternatives explained to me, based upon currently available information. Depending upon the COVID-19 vaccine that I receive, I may require one or two injections. I have had an opportunity to ask questions which have been answered to my satisfaction. I agree to remain at the vaccination location for at least 15 minutes after the vaccine is administered in the event of adverse reaction. I understand that.

• This vaccine is authorized for use under Emergency Use Authorization (EUA) issued by the U.S. Food and Drug Administration (FDA). Under an EUA, the FDA may allow the use of unapproved medical products, or unapproved uses of approved medical products, in an emergency to diagnose, treat, or prevent serious or life-threatening diseases or conditions when certain statutory criteria have been met, including that there are no adequate, approved, and available alternatives.
• It is unclear how long any potential benefits of the vaccine may last. Additional research is needed to answer this question.

• Receiving this vaccine does not eliminate the need for masking, social distancing, and hand hygiene.

• I may still become ill with COVID-19 and may be able to transmit the virus to other individuals.

• This vaccine has not been studied on individuals who are pregnant or breastfeeding and it is recommended that I discuss vaccination with my provider prior to receiving the vaccine. I understand and acknowledge that the record of this vaccine administration to me will be reported to the state and/or federal regulatory bodies in compliance with reporting for inventory management and use of National Stockpile vaccine supply. I agree and authorize my COVID-19 vaccine record to be shared with my primary care physician and included in my health record(s) for continuity of care of care purposes. I further agree and authorize my COVID-19 vaccine record to be shared for quality of care, patient safety, and other research purposes.

☐ I acknowledge this information and consent to receiving the COVID-19 vaccine.

Signature_____ Date_____