Harris County Public Health
Building a Healthy Community

Waiver and Consent Form- Minor and Adult COVID-19 Vaccine

Full Name of Patient _____ **Date of Birth:** _____

MINOR

For PEDIATRIC 5-11 years old: (Must bring consent form signed by parent or guardian to appointment)
I consent and agree to receive a vaccination(s) for COVID-19 from Harris County Public Health (HCPH).
The vaccination will be for the **[please initial]** _____ Pfizer-BioNTech vaccine: Two doses.
You will be informed of when the second (2nd) dose is available

For ADOLESCENT 12-17 years old: (Must bring consent form signed by parent or guardian to appointment)
I consent and agree to receive a vaccination(s) for COVID-19 from Harris County Public Health (HCPH).
The vaccination will be for the **[please initial one]** _____ Pfizer-BioNTech/COMIRNATY vaccine: Two doses.
You will be informed of when the second (2nd) dose is available

_____ Pfizer-BioNTech vaccine: THIRD (3rd) dose consideration*

ADULT

For ADULTS 18 years and older who are unable to consent or HCPH Vacstrac System is down:
I consent and agree to receive a vaccination/s for COVID-19 from Harris County Public Health (HCPH).
The vaccination will be for the **[please initial one]** _____ Pfizer-BioNTech/COMIRNATY or Moderna vaccine: TWO doses.
You will be informed of when the second (2nd) dose is available.

_____ Janssen vaccine: ONE dose **ONLY**

_____ Pfizer-BioNTech or Moderna vaccine: THIRD (3rd) dose consideration*

_____ Pfizer-BioNTech, Moderna, or Janssen vaccine: Booster dose

_____
Patient/Guardian Initials

This consent is for the COVID-19 vaccine and dose(s) selected above.
I agree to stay in the clinical observation area for 15-minutes immediately following the vaccine.
I understand that I have the right to withdraw consent at any time before administration of the COVID-19 vaccine without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
I have been given written information about the vaccine and have had to opportunity to ask questions and to have my questions answered.
I agree to continue practicing safety measures as advised by the CDC (wearing a face mask, social distancing, washing hands, etc.)

MEDICAL CONSENT AND AUTHORIZATION

_____
Patient/Guardian Initials

In the event of an emergency or non-emergency situation requiring medical treatment of the patient during the vaccination process, I/we, the undersigned patient or parent(s)/guardian(s) of the patient, give Harris County Public Health my/our consent and authorization for all medical treatment that is deemed necessary by qualified medical personnel for the proper care and treatment of the patient, including but not limited to administration of first aid, use of an ambulance, and transfer to a hospital.

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PRIVACY NOTICE

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that HCPH collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the agency to correct any information that is determined to be incorrect. For further information, contact Harris County Public Health – Health Information Services at 832-927-7647 or 832-927-7646.

_____
Patient/Guardian Initials

I have been given a copy of HCPH Privacy Notice, which includes the HIPAA Privacy Rule.
I have had the opportunity to have the HCPH Privacy Notice explained to me.
I understand that HCPH will use and disclose my Protected Health Information for treatment, billing and healthcare operations without my written authorization. I understand my rights as described in the Notice. I understand how to make a complaint if I feel my rights have been violated.

RELEASE OF LIABILITY AND ASSUMPTION OF RISK

_____
Patient/Guardian Initials

IN CONSIDERATION OF RECEIVING THE COVID-19 VACCINE, I HEREBY RELEASE, DISCHARGE, AND AGREE TO HOLD HARMLESS HARRIS COUNTY AND HARRIS COUNTY PUBLIC HEALTH, THEIR OFFICERS, COMMISSIONERS, ADMINISTRATORS, OFFICIALS, EMPLOYEES, AGENTS, HEIRS, SUCCESSORS, VOLUNTEERS, AND ASSIGNS FROM AND AGAINST ANY AND ALL CLAIMS, DEMANDS, COSTS (INCLUDING ATTORNEY'S FEES AND EXPERT FEES), AND CAUSES OF ACTION FOR INJURY, DEATH AND ALL OTHER DAMAGES ASSOCIATED WITH OR ARISING FROM RECEIVING THE COVID-19 VACCINE TO THE FULLEST EXTENT ALLOWED BY LAW. THIS RELEASE AND INDEMNITY ALSO EXTENDS TO CLAIMS THAT OTHERWISE MIGHT BE ASSERTED BY MY HEIRS, FAMILY, AND/OR LEGAL REPRESENTATIVES.

REQUIRED FOR ALL PATIENTS

I attest that the information I have provided on this form is accurate and correct to the best of my knowledge. I hereby give my informed consent to the procedure/treatment/vaccination listed above. No warranty or guarantee has been made to me by the HCPH staff or contractors regarding the care or services that will be provided by HCPH. I certify that the services and care to be provided have been fully explained to me and my questions have been answered to my satisfaction. I attest that I am an adult who can legally consent for the person named above to receive the COVID-19 vaccine. I freely and voluntarily give my consent for the administration of the COVID-19 vaccine.

_____ _____ _____
Full Signature of Patient/Parent or Legal Guardian | Date | Relationship to Patient

Address of signor: _____

TRANSLATOR

I have provided an accurate translation of this information to the patient. They have stated that they understand the information and has had an opportunity to have their questions answered and voluntarily consents.

_____ _____
Signature of Translator | Date

_____
Name of Translator