COMAL COUNTY
OFFICE OF PUBLIC HEALTH

Name:_____ **Date of Birth**_____ **Phone number:**_____

Address:_____ **City, State, Zip:**_____

Emergency Use Authorization

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

_____

Recipient/Guardian Date Relationship to patient, if other than recipient

---------- **For Office Use** ----------

- ☐ I have reviewed side effects with patient (and parent or guardian as applicable)
- ☐ I confirm the patient was given an opportunity to ask questions about the vaccination, and all questions asked by them have been answered to the best of my ability.

Vaccinator signature:_____

Date Administered:_____ **Site**:_____ **Route**:_____

Administered by: Printed Name_____

Signature & Title_____

ADD LABEL HERE