Harris County Public Health
Building a Healthy Community

JANSSEN COVID-19 Vaccine Waiver and Consent Form

Patient's First Name: _____ Patient's Last Name: _____

Patient's Date of Birth: _____/_____/_____ Patient's Age: _____
Month Day Year

_____
Patient/Guardian Initials

JANSSEN COVID-19 VACCINE CONSENT: I declare that I or the person named above is **at least 18 years of age**. Further, I consent and agree to receive the Janssen COVID-19 vaccine upon my request despite significant known and potential risks. I've been informed mRNA COVID-19 vaccines are preferred and have been made available to me. I understand this vaccine can cause thrombosis (blood clots) with thrombocytopenia (low platelets) syndrome (TTS), which may be life-threatening. Among the reported cases of TTS, symptoms began approximately one to two weeks after vaccination. I should seek medical care immediately if I develop shortness of breath, chest pain, leg swelling, persistent abdominal pain, severe or persistent headaches or blurred vision, easy bruising, or tiny blood spots under the skin beyond the site of the in jection. I should not receive this vaccine if I've had a severe allergic reaction after a previous dose of this vaccine, had a severe allergic reaction to any ingredient of this vaccine or had a blood clot along with a low level of platelets (blood cells that help your body stop bleeding) following this vaccine or following AstraZeneca's COVID-19 vaccine.

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EMERGENCY USE AUTHORIZATION AND OBSERVATION: I have read or had explained to me the information contained in the *Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers* for the Janssen COVID-19 vaccine and understand the risks and benefits of the vaccine. I have had a chance to ask questions which have been answered to my satisfaction. 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.

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Patient/Guardian Initials

MEDICAL CONSENT AND AUTHORIZATION: In the event of an emergency or non-emergency situation requiring medical treatment of the patient during the vaccination process, I, the undersigned patient, or parent/guardian of the patient, give Harris County Public Health my 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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Patient/Guardian Initials

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. 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.

_____
Patient/Guardian Initials

RELEASE OF LIABILITY AND ASSUMPTION OF RISK: 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 REPRESENTATIVE.

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 Janssen COVID-19 vaccine. I freely and voluntarily give my consent for the administration of the Janssen COVID-19 vaccine.

Signature of Patient/Guardian: _____ Date: _____

Please Print Patient/Guardian name: _____ Relationship: _____

Address: _____ Phone number: _____

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: _____

Please Print Translator name: _____