GOVERNMENT OF BERMUDA
Department of Health

COVID-19 Vaccine Information and Consent Form

Covid-19 Vaccines

Vaccines have been developed against the novel coronavirus (SARS-CoV-2) ("**Covid-19**") and if Covid-19 is contracted, it can result in acute respiratory illness as well as other health complications. A Covid-19 vaccine (the "**vaccine**") is being given to priority groups for Emergency Use. Information regarding vaccines which have been approved strongly suggests they are safe and effective in the prevention and mitigation of the COVID-19 disease. The decision to use the vaccine is based on the threat of serious disease and death in our community. The vaccine is the best protection against Covid-19 and its complications and it is voluntary to take.

The vaccine is not a live virus and you cannot get COVID-19 as a result of taking the vaccine. Currently, it is unclear if the vaccine will prevent the spread of Covid-19 and the duration of protection is unknown.

The Pfizer/BioTech COVID-19 vaccine contains the Messenger RNA which is packaged in a lipid envelop that allows the messenger RNA to enter the cells. This will cause the cells to produce the COVID-19 cell protein. When the protein is released from the cells it will cause 'an immune reaction' and develop antibodies against the virus. This will help reduce the impact of the virus on the body.

You will need two (2) shots given three (3) weeks apart. The shot is given in the muscle of the upper arm. It is recommended you receive the 2 shot series using the same vaccine type. The vaccine may not protect everyone who receives it. After being vaccinated, you will still need to adhere to public health guidelines i.e. wear a face mask in public, maintain physical distancing and use hand hygiene measures.

Confidential records of all persons who receive the vaccine will be maintained in the Bermuda Immunization Information System. Persons should also be given a handheld record for their personal record and safe keeping.

Who Should Get Covid-19 Vaccine?

- Health care workers.
- Persons over the age of 65.
- Residents of Long-Term Care Facilities or institutions.
- Persons with medical conditions that increase the risk of complications.
- All persons who desire to voluntarily receive the vaccine.

Who should NOT get this vaccine or requires clearance from their Doctor, are:

- Persons with a severe allergic reaction to the first shot or any ingredient of the vaccine.
- Persons with severe allergic reactions to vaccines, medication or foods should consult with their physician.
- Persons who are not feeling well or have a fever.
- Pregnant or breastfeeding women.
- Women of childbearing age, advised to avoid pregnancy for at least 2 months after their second shot.
- Children under 16 years of age.
- Persons who have an immunodeficiency disorder may be given the vaccine under certain conditions and once prescribed by their healthcare provider.
- Persons who have received another COVID-19 vaccine.

If you have any COVID-19 or flu symptoms and are in a high-risk group, or are very worried about your illness; contact your healthcare provider before getting the vaccine. If you are in a high-risk group; it is

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best that you contact your healthcare provider.

Side effects and risks that may occur

With any vaccine, there is a chance of side effects and allergic reactions. These are usually mild and go away on their own, but serious reactions are also possible. Most people who have received the vaccine do not have any problems. Minor reactions following vaccination include:

- Soreness or redness and itching where the shot was given.
- Headache, tiredness, muscle aches and chills.
- Joint pain, fever, nausea and feeling unwell.

If these reactions occur, they usually begin soon after the shot and last 1 or 2 days. Side effects have been more commonly reported after the 2nd shot.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would usually start a few minutes to one hour after the vaccination.

If you have a severe allergic reaction such as difficulty breathing or face swelling, **contact your doctor immediately or call 911**.

The Department of Health monitors vaccine reactions. If you have a concern you should contact your doctor to make a report. Serious adverse reactions may be reported to Bermuda's global health partners.

DECLARATION AND CONSENT:

1. I agree to take the vaccine voluntarily in accordance with the terms and conditions of this Covid-19 Vaccine Information and Consent Form ("**Form**") and any guidance or instructions provided by the Ministry of Health.
2. I understand and consent to my information and data, including medical information ("**Information**"), being collected and saved on the *Bermuda Immunization Information System ('BIIS')* and used for analysis or research related to Covid-19 public health matters. This Information may also be shared with Government of Bermuda ("**Government**") partners who are subject to the *BIIS Security and Confidentiality Policy.*
3. I agree that if I am a victim of bodily or other injury suffered or incurred as a result of voluntarily taking this vaccination, I will not hold the Government liable. I shall indemnify, keep indemnified and defend the Government against all actions, claims, demands, penalties, fines, interests, costs and expenses (including legal expense) arising as a result of me voluntarily taking the vaccine, consenting to using my Information or completing this Form either for me or on behalf of another person.
4. I understand and acknowledge that my consent shall be enforceable against my executors, successors and legal representative(s).

By checking the box below, I acknowledge that I have read this Form including the *Ministry of Health Covid-19 Vaccine Information Sheet,* and I understand that there are certain risks and side effects associated with the taking of any COVID-19 vaccine. I confirm that I voluntarily consent to receiving a *Covid-19* vaccine and understand that this consent shall be ongoing.

☐ **Check box to confirm consent**.

I, (print name) ____, acknowledge that I have read and agree to the terms contained in this Form.

Date: ______________________ Signature:______________________________

If under 18 years of age: Parent or Guardian declaration: I have read, understood and agreed to the foregoing declaration and consent contained in the Form. I represent and warrant that I am the parent or legal guardian of the individual named below, who is a minor, and that I am entitled and authorized to sign and grant the rights provided in the Form, including providing any information or data about the minor, to the Government. I shall indemnify, keep indemnified and defend the Government of Bermuda ("Government") against any action, claim, loss, damage or expense (including legal expense) if the minor disavows the consent contained in the Form because the minor was a minor or arising from the Government's use of the minor's information or data, or for any other grounds whatsoever.

☐ **Check box to confirm consent**.

Signature of Parent/Guardian: ______________________ Date: ____________

Print name of Parent/Guardian: ________________________

Print Name of minor: _____________________

Relationship to the minor: ___________________________

Declaration of person with authority to sign on behalf of incapacitated adult: On behalf of the person who does not have the capacity to consent to the Form (the "**person**"), I represent and warrant that I am entitled and authorized to sign and grant the rights provided in the Form, to the Government. On behalf of the person, I shall indemnify, keep indemnified and defend the Government of Bermuda against any action, claim, loss, damage or expense (including legal expense), in the event that the person disavows the consent contained in the Form because the person did not have the capacity or for any other grounds whatsoever.

☐ **Check box to confirm consent**. Print name of adult: _______________________

Authorized person name: __________________________

Authorized person signature:________________________

Relationship to the incapacitated adult: ___________________________

Date: ____________

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Coronavirus (COVID-19) – CLINICAL CHECK SHEET

TO BE COMPLETED BY THE HEALTH PROFESSIONAL ADMINISTERING VACCINE

Name of person: ____

Date of immunization: ____________________________

Date of Birth dd_________mmm___________yyyy___________

Clinical/Area or Provider ID: ________________________

COVID Vaccine Manufacturer: _________________ Batch #: ___________________

Vaccination site: L/R deltoid

Administering nurse/doctor signature: ______________________________

*__Client classification code:__ ____

1. Healthy individual (≥ 16 – 64 years)

2. Adult > 65 years

3. Adult with pre-existing medical condition

4. Healthcare worker/Caregiver/Essential service worker

Health Provider Checklist Initial ____

Are you well today? Y ☐ N ☐ Had any vaccines < 1/12 Y ☐ N ☐

Previous reaction to vaccine Y ☐ N ☐ Do you have any bleeding disorder? Y ☐ N ☐

Do you have a fever > 100°? Y ☐ N ☐

Are you taking any anticoagulant medication? Y ☐ N ☐

Do you have any severe allergic reaction to any food or medication? Y ☐ N ☐