**DDS Providers- COVID-19 Vaccine Administration and Consent Form**

Date:­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Individual’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_is served by the

 *(individual’s name)*

Connecticut Department of Developmental Services (DDS) and has been identified as being eligible to receive the COVID-19 vaccine. Prior to administering the vaccine, DDS and DDS qualified contracted providers are required to receive signed consent from the legal representative for the above-mentioned individual.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have received and reviewed the

  *(name of legal representative/guardian)*

Vaccine Fact Sheets (Pfizer-BioNTech, Moderna, and Janssen/Johnson & Johnson) for each of the available COVID-19 vaccines. I understand the benefits and risks associated with each of the vaccines.

I understand that DDS may not have sufficient advance notice to inform me of which COVID-19 vaccine will be administered to the above-named individual; therefore, the Fact Sheet for each of the approved vaccines has been provided to me.

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* By checking this box, I am confirming my **consent** for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to receive the COVID-19 vaccine. *(individual’s name)*

I understand that the vaccine may be administered by DDS directly or by a contracted vendor or pharmacy.

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* By checking this box, I am **declining** for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to receive the COVID-19 vaccine. *(individual’s name)*

I understand by declining the administration of the COVID-19 vaccine at this time, I have the ability to change this decision in the future and will be required to complete a new consent form in order for such change to be determined valid.

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***(signature of legal representative/guardian)* (*date of signature*)**

**If written consent or declination by the legal representative is not feasible, consent may be obtained by a nurse and one other agency employee through video or audio conference.**

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***(name of legal representative/guardian)* (*date of verbal consent*)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***(name and signature of nurse witness) (date)***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***(name, signature and title of second witness) (date)***