COVID-19 VACCINATION BOOSTER CLINIC CONSENT AND RELEASE

Student's Name:_____ Date of Birth:_____

At Cushing Academy ("Cushing" or the "Academy"), our top priority is the safety of our community members. Local and national public health officials have emphasized the importance of receiving a COVID-19 vaccination booster in order to limit the impact and the spread of the COVID-19 (SARS-COV-2) virus. The U.S. Food and Drug Administration has issued an emergency use authorization for the Pfizer-BioNTech COVID-19 vaccine for individuals 12 and older at least five (5) months after their primary series. The Academy will require all students to receive a COVID-19 booster shot by April 1, 2022, or have an approved exemption. To facilitate access to the booster shot, Westminster Pharmacy in Gardner will be hosting a mobile vaccine booster clinic on Cushing's campus for the Cushing community on February 27, 2022 (the "COVID-19 Vaccine Booster Clinic").

Participation in the COVID-19 Vaccine Booster Clinic is completely voluntary. The cost of the COVID-19 Vaccine Booster Clinic will be covered by a participant's health insurance. In order for an eligible student to participate, this COVID-19 Vaccination Booster Clinic Consent And Release form must be signed by the student's parent(s)/legal guardian(s). Parent(s) and/or legal guardian(s) may also be required to complete certain paperwork required by Westminster Pharmacy. If families have any questions about the COVID-19 Vaccine Booster Clinic, they may contact the Health Services team at healthcenter@cushing.org.

PARENTAL CONSENT AND RELEASE

As the parent(s)/guardian(s) of the above-named student (the "Student"), I authorize the Student to participate in the COVID-19 Vaccine Booster Clinic. I understand that my consent allows Westminster Pharmacy and its healthcare providers to administer the COVID-19 vaccine booster to the Student.

I understand that Westminster Pharmacy, and not the Academy, is responsible for implementing and running the COVID-19 Vaccine Booster Clinic. Though the Academy will take reasonable measures to help ensure the safety of the Student while participating in the COVID-19 Vaccine Booster Clinic, I understand and agree that the Academy is not responsible for, and cannot guarantee, the health and safety of any student-participants. I agree that prior to the Student's participation in the COVID-19 Vaccine Booster Clinic, I will discuss with the Student the appropriate health and safety precautions for participation in the COVID-19 Vaccine Booster Clinic and receiving the COVID-19 vaccine booster.

I recognize that there are dangers and risks to which the Student may be exposed by participating in the COVID-19 Vaccine Booster Clinic. I understand that these risks include, but are not limited to, side effects to receiving the COVID-19 vaccine booster (*e.g.*, pain at the site of the injection, tiredness, headache, muscle and joint aches, nausea and vomiting, fever or chills, severe allergic reactions, and other bodily injuries), as well as the potential negligence of Cushing and/or Westminster Pharmacy and its healthcare providers. As the parent(s)/legal guardian(s) of the Student, I assume these risks by giving the Student my permission and consent to participate in the COVID-19 Vaccine Booster Clinic.

In consideration of the Student being permitted to participate in the COVID-19 Vaccine Booster Clinic, I agree, on my own behalf and that of the Student and our heirs, executors, administrators, personal representatives, successors, and/or assigns ("Releasors"), to forever release, hold harmless, and covenant not to sue the Academy, its employees, officers, directors, volunteers, members, trustees, and representatives, from any claims, suits, liabilities, or actions, including, but not limited to, claims of

negligence (but not gross negligence), which Releasors may have now or in the future, which arise directly or indirectly out of the Student's participation in the COVID-19 Vaccine Booster Clinic. These provisions do not govern any claims that cannot be released by private agreement.

I have read this form in its entirety and understand what it means. By signing this form, I affirm that I have legal custody of the Student and am authorized to sign on the Student's behalf. If I am signing this form via Magnus Health, I acknowledge and agree that my electronic signature has the same legal effect and validity as a written signature and that this form is valid and will be given the same legal effect as a written and signed form.

Signature of Parent/Legal Guardian: _____ Date: _____

Print Full Name of Parent/Legal Guardian: _____

Signature of Student (18+):_____Date: _____

Vaccine Administration Consent Form

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Section A (Please print clearly.)

First name: Last name:

Age: Date of birth: Gender (check one): ☐ Female ☐ Male ☐ Non-binary

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander Ethnicity: ☐ Hispanic ☐ non-Hispanic

Home address:

City: State: ZIP Code:

Email address: Phone number:

Primary care physician name: Physician phone: Physician fax:

Please check the vaccinations you wish to receive today.

☐ Seasonal Influenza	☐ Hepatitis B	☐ Pneumococcal	☐ Meningococcal
☐ COVID-19	☐ Chickenpox (varicella)	☐ Tetanus/TDap	☐ MMR
☐ Hepatitis A	☐ HPV	☐ Shingles (zoster)	☐ Other

Section B (The following questions will help us determine your eligibility for vaccination today.)

General Vaccine Screening Questions	Yes	No
1. Do you feel sick today?	☐	☐
2. Do you have any health conditions such as heart disease, diabetes or asthma? If yes, please list:	☐	☐
3. Do you have allergies to latex, medications, food or vaccines (e.g., eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list:	☐	☐
4. Have you ever had a reaction (allergic or otherwise) after receiving an immunization, including fainting or feeling dizzy?	☐	☐
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré Syndrome (a condition that causes paralysis) or other nervous system problem?	☐	☐
6. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS or transplant)?	☐	☐
7. For women: Are you pregnant or considering becoming pregnant in the next month?	☐	☐
Live vaccines	**Yes**	**No**
8. Have you received any vaccinations or skin tests in the past four weeks? If yes, please list:	☐	☐
9. Are you currently on home infusions, weekly injections such as Humira™ (adalimumab), Remicade™ (infliximab) or Enbrel™ (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	☐	☐
10. Are you currently taking high-dose steroid therapy (prednisone > 20 mg/day or equivalent) for longer than two weeks?	☐	☐
11. Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?	☐	☐
12. Are you currently taking any antibiotics, antiviral or antimalarial medications? (Typhoid only)	☐	☐
13. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)	☐	☐
14. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)	☐	☐
15. Do you have a nasal condition serious enough to make breathing difficult (e.g., very stuffy nose)?	☐	☐

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Section C

COVID-19 Vaccine Screening Questions	Yes	No
16. Have you ever received a dose of COVID-19 vaccine? If yes, which product? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product If yes, will this be your ☐ 2nd dose or ☐ 3rd dose Date of last dose:	☐	☐
17. Have you ever had an allergic reaction to a component of a COVID-19 vaccine, including either of the following:		
• Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐
• Polysorbate, which is found in some vaccines, film-coated tablets and intravenous steroids	☐	☐
- A previous dose of COVID-19 vaccine (This includes a severe allergic reaction, such as anaphylaxis, that required treatment with epinephrine or EpiPen™, or that caused you to go to the hospital. It also includes an allergic reaction that caused hives, swelling or respiratory distress, including wheezing.)		

18. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (e.g., HIV, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré Syndrome (GBS)

Section D (Consent and Release)

I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I request the vaccine(s) be given to me or to the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release.

Signature of person to receive vaccine and VIS: Date:

(or parent/guardian, if recipient is younger than 18 years)

Insurance information and authorization:

☐ I hereby authorize the pharmacy to bill my insurance on my behalf for the immunizations and receive payment.

Non-medicare	Pharmacy	Medical	Medicare Card No. (Red, White and Blue Card)
Insurance plan name			
Member/recipient ID			
RX Bin		NA	
RX PCN		NA	
Group No.			

Vaccine	MFR	Date admin.	Vaccine lot No.	Exp. date	Dosage	Injection site	VIS/EUA date	Dose in series
COVID-19								
Influenza								
Other								

Immunizer name (print): **Immunizer signature:**