NAME (Last)	(First)	Date of Birth: ______/______/_________	**Age:**

“COVID-19 VACCINATION CONSENT AND RELEASE FORM”:
I hereby give consent to allow Curogram Inc. to administer a COVID-19 vaccination to me or theminor for whom I am legal guardian, and hereby release, indemnify, and hold harmless Curogram and CORE Community Organized Relief Effort (“CORE”), their agents, officers, directors, assigns, contractors, successors, and personnel from any liability that may arise out oftheir acts and omissions. I understand that I may ask questions about the vaccination or my care, or refuse treatment at this time, and that I am voluntarily proceeding.

______________________________ ______________________________

Signature Date

______________________________ ______________________________

Printed Name Relationship to Patient (If Applicable)

HIPAA Authorization For Disclosure of COVID-19 Vaccination Records
I hereby voluntarily authorize the disclosure of my COVID-19 vaccination records, including vaccination status, provided by CORE Community Organized Relief Effort (“CORE”) throughCurogram Inc. (“Curogram”), to:

- Me via email, even though email is not a completely secure means ofcommunication.
- Me via SMS, even though SMS is not a completely secure means ofcommunication.
- CORE
- Curogram

I also understand and agree to the following:

The purpose for which my COVID-19 vaccination records will be disclosed to the above partiesis public health activities and purposes.
I may refuse to provide this authorization.
I may revoke this authorization at any time in writing emailed to Curogram at records@curogram.com, except to the extent that action has been taken in reliance on thisauthorization.

If this authorization has not been revoked, it will terminate 1 year from the date of effectivenessbelow.
I have a right to request and receive a copy of this authorization.

Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtainingthis authorization if such conditioning is prohibited by the HIPAA Privacy Rule.

Any information disclosed pursuant to this authorization may be subject to redisclosure by therecipient, and any redisclosure may not be subject to HIPAA.

______________________________ ______________________________

Signature Date

______________________________ ______________________________

Printed Name Relationship to Patient (If Applicable)

Please answer the health questions below:	Yes	No	Do Not Know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine? *If yes, which vaccine product: □ Pfizer □ Moderna □Janssen □ Other: ___________			
3. Have you ever had a severe allergic reaction that required treatment with Epinephrine or EpiPen, or caused you to go to the hospital, caused hives, swelling, or respiratory distress including wheezing?			
*Was the severe reaction after receiving a COVID-19 vaccine?			
*Was the severe reaction after receiving another vaccine or another injectable medication?			
4. Check all that apply to you: □Have a history of myocarditis or pericarditis □Have a history of Guillain-Barre Syndrome □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 bleeding disorder or take blood thinners □Have a history of heparin-induced thrombocytopenia (HIT) □Am currently pregnant or breastfeeding □Have received dermal fillers			
5. Check all that apply to you: □ Have a weakened immune system (i.e., HIV infection, cancer): If yes list condition: ___________________________ □ Take immunosuppressive drugs or therapies: If yes, please list: _______________________________________ □ 18-64 with underlying chronic health condition(s): If yes, please list: ______________________________________ □Resident of long term care facility (nursing home, senior living facility, assisted living) □ At high risk of occupational/institutional exposure to COVID-19			

I (_________________________(Name)):

- Have received, read, and understand the Emergency Use Authorization Fact Sheet and/or Vaccine Information Statement for the vaccine I am receiving;
- Have received and signed the Curogram HIPAA Authorization allowing for the release of my COVID-19 vaccine records, including vaccine status;
- Have had the opportunity to discuss any medical concerns with my healthcare provider or a healthcare provider at the time of my vaccination and my questions were answered to my satisfaction;
- Understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result;
- Understand that I should remain in the vaccine administration area for 15 minutes after the vaccination to be monitored for any potential adverse reactions;
- Understand that if I have experienced previous anaphylactic reactions I should stay for 30 minutes after the vaccination to be monitored for any potential adverse reactions;
- Understand that if I experience side effects that I should do the following:
  - Contact doctor;
  - Call 911.

PLEASE ASK QUESTIONS BEFORE RECEIVING THE COVID-19 VACCINE.

I understand the risks of this vaccine and ask that this vaccine be given to me or to the person named above for whom I am authorized to make this request.

______________________________ ______________________________

Signature Date

______________________________ ______________________________

Printed Name Relationship to Patient (If Applicable)