State of Connecticut
Department of Developmental Services

Ned Lamont
Governor

Jordan A. Scheff
Commissioner

Peter Mason
Deputy Commissioner

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)*