GEORGIA DEPARTMENT OF PUBLIC HEALTH

COVID-19 Vaccine
INFORMATION AND CONSENT FORM

NAME (Last)	(First)	(Middle)	Date of Birth: _____/_____/_____	Age:
ADDRESS			EMAIL	
CITY	STATE	ZIP	DAYTIME PHONE NUMBER	
EMERGENCY CONTACT: Name		Relation	Phone Number	

Race: (check only 1)	Ethnicity: (check only 1)	Primary Language:	Gender:
☐ Asian/Polynesian ☐ Black ☐ Multiracial ☐ Native Am/Alaskan ☐ White ☐ Unknown	☐ Not Hispanic ☐ Hispanic ☐ Unknown	☐ English ☐ Spanish ☐ Other _____	☐ Male ☐ Female

Please answer the health questions below:	Yes	No	Do Not Know
1. Are you feeling sick today **OR** are you currently in an isolation or quarantine period for COVID-19?			
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
- ☐ 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
- ☐ 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

5. Check all that apply to you:
- ☐ Have a weakened immune system due to a current condition or diagnosis. If yes list condition: _____
- ☐ Take immunosuppressive drugs or therapies: If yes, please list: _____

I have been given a copy and have read the Emergency Use Authorization (EUA) and reviewed the FDA Fact Sheet for Recipients and Caregivers for the COVID-19 vaccine product I will be administered (choose one of the following):

____Moderna (age 6 months - 5 years); ____ Moderna (age 6 years - 11); _____ Moderna (age 12 yrs. & over);

____Pfizer (age 6 months - 4 yrs.); ____Pfizer (age 5 yrs - 11); ____ Pfizer (age 12 yrs. & over); ____Janssen (age 18 & over)

- An administration fee may be billed to third-party payers. I authorize the Southeast Health District to bill any and all third-party payers for this service. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits or payment of medical benefits either to myself or to the party who accepts assignment for services described herein.
- I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine indicated and ask that it be given to me, or the person named for whom I am authorized to make this request.
- **My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine. Those with previous anaphylactic reactions should stay for 30 minutes.**

_____ _____ X_____

Date **Print Name** **Patient or Parent/Guardian Signature**

FOR ADMINISTRATIVE USE ONLY

Vaccine recipient/caregiver was provided the following EUA/FDA Fact Sheet:

- ☐ Moderna (age 12 & over) https://www.fda.gov/media/157233/download
- ☐ Moderna (age 6 -11 yrs) https://www.fda.gov/media/159310/download
- ☐ Moderna (age 6 months - 5 years) https://www.fda.gov/media/159309/download
- ☐ Pfizer (age 12 & over) https://www.fda.gov/media/153716/download
- ☐ Pfizer (age 5 – 11 yrs) https://www.fda.gov/media/153717/download
- ☐ Pfizer (age 6 months through 4 years) https://www.fda.gov/media/159312/download
- ☐ Janssen https://www.fda.gov/media/146305/download

Vaccine COVID-19	Vaccine Manufacturer	Dose	Route - IM	Lot Number	Expiration Date
Dose: ☐ 1st ☐ 2nd ☐ 3rd ☐ Booster 1 ☐ Booster 2	☐ MODERNA ☐ PFIZER ☐ JANSSEN	____0.5 ml ____0.25 ml ____0.3 ml ____0.2 ml	☐ LEFT Arm ☐ RIGHT Arm ☐ LEFT Thigh ☐ RIGHT Thigh		
				Signature of Vaccine Administrator	**Date Administered**