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** ☐ **Novavax** ***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 (i.e., HIV infection, cancer): 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 – 11 years); ___ Moderna (age 12 & over);
____ Pfizer (age 6 months – 4 years); ___Pfizer (age 5 – 11 years); ___ Pfizer (age 12 & over);
____ Janssen (age 18 & over); ____Novavax (age 12 & 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:

☐ **Pfizer-BioNTech:** https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/comirnaty-and-pfizer-biontech-covid-19-vaccine
☐ **Moderna:** https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/spikevax-and-moderna-covid-19-vaccine
☐ **Janssen:** https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/janssen-covid-19-vaccine
☐ **Novavax:** https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/novavax-covid-19-vaccine-adjuvanted#additional

Vaccine COVID-19	**Vaccine Manufacturer**	**Dose**	**Route - IM**	**Lot Number**	**Expiration Date**
Dose: ☐ 1st ☐ 2nd ☐ 3rd ☐ Booster	☐ MODERNA ☐ PFIZER ☐ JANSSEN ☐ NOVAVAX	____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**