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<br>☐ Native Am/Alaskan ☐ White ☐ Unknown | ☐ Not Hispanic<br>☐ Hispanic ☐ Unknown | ☐ English ☐ Spanish<br>☐ Other _____ | ☐ Male<br>☐ Female |

| **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?<br>*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 through 11 years); ____ Moderna (age 12 years & over);**
**____ Pfizer (age 6 months through 4 years); ___Pfizer (age 5 through 11 years); ___ Pfizer (age 12 years & over);**
**____Novavax (age 12 years and over)**

I received a copy of the NOTICE OF PRIVACY POLICY FORM from the County Board of Health regarding my health information rights and the Board of Health responsibilities. I authorize the release of any medical or other information necessary for care, treatment and claim processing. I authorize payment of medical benefits to the party who accepts assignment for services described herein. Should my insurance not cover payment I understand I will be responsible for payment.

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/vaccines-blood-biologics/coronavirus-covid-19-cber-regulated-biologics/pfizer-biontech-covid-19-vaccine
☐ **Moderna**: https://www.fda.gov/vaccines-blood-biologics/coronavirus-covid-19-cber-regulated-biologics/moderna-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:**<br>☐ 1st<br>☐ 2nd<br>☐ 3rd<br>☐ _____ | ☐ **MODERNA**<br>☐ **NOVAVAX**<br>☐ **PFIZER** | ____0.25 mL<br>____0.5 mL<br>____0.3 mL | ☐ **LEFT Deltoid**<br>☐ **RIGHT Deltoid**<br>☐ **LEFT Thigh**<br>☐ **RIGHT Thigh** | | |
| | | | | **Signature of Vaccine Administrator** | **Date Administered** |