GEORGIA DEPARTMENT OF PUBLIC HEALTH

COVID-19 Vaccine
INFORMATION AND CONSENT FORM

NAME (Last)	(First)	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 ☐ Other _____	☐ Male ☐ 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? *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): ____Pfizer (age 6 months through 4); ____Pfizer (age 5 through 11); ____ Pfizer (age 12 & over); _____ Moderna (age 6 months through 5); ____ Moderna (age 6 through 11); _____ Moderna (age 12 and over); _____ Janssen (age 18 and over); ____ Novavax (age 12 and over).
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 provided:
☐ **Pfizer-BioNTech** (Fact Sheets) https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/comirnaty-and-pfizer-biontech-covid-19-vaccine
☐ **Moderna** (Fact Sheets) https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/spikevax-and-moderna-covid-19-vaccine
☐ **Janssen** (Fact Sheets) https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/janssen-covid-19-vaccine
☐ **Novavax** (Fact Sheets) https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/novavax-covid-19-vaccine-adjuvanted#additional

Vaccine	Dose	Route	Date Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
	_____ml ☐ 1st _____ml ☐ 2nd _____ml ☐ 3rd _____ml ☐ 4th	IM - L Arm IM - R Arm IM - L Leg IM - R Leg					