GEORGIA DEPARTMENT OF PUBLIC HEALTH

COVID-19 Vaccine
INFORMATION AND CONSENT FORM

☐ 3rd DOSE
☐ BOOSTER

NAME (Last)	(First)	Date of Birth: / /	**Age:**
ADDRESS		**COUNTY OF RESIDENCE**	
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	☐ Not Hispanic	☐ English	☐ Male
☐ Native Am/Alaskan ☐ White ☐ Unknown	☐ Hispanic ☐ Unknown	☐ Other	☐ 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 so, when? 1st Dose_____ 2nd Dose_____** *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 (i.e., HIV infection, cancer): If yes list condition: _____
- ☐ Take immunosuppressive drugs or therapies: If yes, please list: _____
- ☐ Underlying chronic health condition(s): 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 5 - 11) _____ Pfizer (age 12 & over) _____ Moderna (age 18 & over) _____ Janssen (age 18 & 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 (age 12 and over)	https://www.fda.gov/media/153716/download
Pfizer (age 5 through 11)	https://www.fda.gov/media/153717/download
Moderna	https://www.fda.gov/media/144638/download
Janssen	https://www.fda.gov/media/146305/download

Vaccine	Dose	Route	Date Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	_____ ml ☐ 1st _____ ml ☐ 2nd _____ ml ☐ 3rd _____ ml ☐ 4th	☐ IM - L Arm ☐ IM - R Arm ☐ IM - L Leg ☐ IM - R Leg					

PLEASE COMPLETE REQUESTED INSURANCE INFORMATION ON THE OTHER SIDE

MEDICAL INSURANCE INFORMATION

NAME OF POLICY HOLDER: _____ POLICY HOLDER DOB: _____/_____/_____

MEMBER ID #: _____ NAME OF INSURANCE: _____

Relationship to Patient: PARENT/GUARDIAN SPOUSE SELF OTHER: _____
(Circle One)

_____ CHECK IF UNINSURED

_____ CHECK IF INSURANCE NOT PROVIDED

DISCLAIMER - By providing your insurance information above, you are authorizing West Central Health District to bill your insurance company for administering the COVID-19 vaccine. You will not be billed for any charges not paid by your insurance company.

DISCLAIMER: HRA dollars may be used to satisfy the claim if you have an HRA account.