COVID-19 Vaccine Consent Form

Section 1: Personal Information

NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH** month_____day_____ year_____
PHONE NUMBER	**CELL PHONE NUMBER**		**AGE** / **GENDER** Male / Female
ADDRESS			**EMAIL ADDRESS**
CITY	**STATE**	**ZIP**	
RACE:			**ETHNICITY:** NON-HISPANIC HISPANIC

Section 2: Screening for Vaccine Eligibility

	YES	NO
1. Are you feeling sick today?	☐	☐
2. Have you ever received a dose of COVID-19 Vaccine? Name: [ ] Moderna [ ] Pfizer [ ] Other	☐	☐
3. Have you ever had an allergic reaction to: a. A component of a COVID-19 vaccine b. A previous dose of a COVID-19 Vaccine	☐	☐
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	☐	☐
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a Vaccine, this would include food, environmental or oral medication allergies.	☐	☐
6. Have you received any vaccine in the last 14 days?	☐	☐
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? When?	☐	☐
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐
10. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐
11. Are you pregnant or breastfeeding?	☐	☐

CONSENT FOR VACCINATION:

I have read and had explained to me the COVID-19 Vaccine EUA Fact Sheet for Recipients. I understand the risks and benefits. I give consent to YourTown Health and its staff to be vaccinated with this COVID-19 vaccine. I understand a 3rd dose (booster) of the COVID-19 vaccine is authorized and recommended for moderately to severely immunocompromised individuals: a) receiving active cancer treatment b) received an organ transplant and am taking medicine to suppress my immune system c) moderate or severe primary immunodeficiency d) advanced or untreated HIV infection e) active treatment with high-dose corticosteroids f) another medical condition that causes my immune system to be moderately to severely compromised and for which my treating physician recommends I receive a 3rd dose (booster) of the COVID-19 vaccine.

Signature of Patient or Parent/Guardian _____ Date: _____

Permission to release vaccine information to the Georgia Registry of Immunizations (GRITS). Initials _____

Section 3: Vaccination Record (FOR ADMINSTRATIVE USE ONLY)

Vaccine	Date Dose Administered	Route/Location	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
COVID-19	1._____ 2._____ 3._____	____Deltoid ____Deltoid ____Deltoid	___First Dose ___Second Dose ___Booster	**MODERNA**	Lot_____ Lot_____ Lot_____	YourTown Health
COVID-19	1._____ 2._____ 3._____	____Deltoid ____Deltoid ____Deltoid	____First Dose ____Second Dose ____Booster	**PFIZER**	Lot_____ Lot_____ Lot_____	YourTown Health
COVID-19		_____Deltoid	Single Dose	**JANSSEN/J&J**	Lot_____	YourTown Health