# COVID-19 Vaccine Consent Form

| **Patient Name (please print)** | | | |
|---|---|---|---|
| **DOB** | | **Gender** | |
| **Address**   **City**   **State**   **Zip** | | | **Email** |
| **Parent/Guardian/Surrogate (If Applicable, Please Print)** | | | **Phone** |
| **Ethnicity** | **Ethnicity Key:**<br>DECL – Declined<br>HIS – Hispanic Origin<br>NHL – Non-Hispanic Origin<br>UNK - Unknown | **Race** | **Race Key:**<br>AIA – Native American or Alaskan<br>ASN – Asian<br>BAA – African American or Black<br>DECL – Declined<br>NHP – Native Hawaiian or Pacific Islander<br>OTH – Other or Multiracial<br>WHT – White |

Internal Medicine of Savannah is authorized to offer the COVID-19 Vaccine to publics based on guidance from the Centers for Disease Control and the Georgia Department of Public Health.

COVID-19 Vaccine side effects that have been reported include but are not limited to injection site pain • tiredness • headache • muscle pain • chills • joint pain • fever • injection site swelling • injection site redness • nausea • feeling unwell • swollen lymph nodes (lymphadenopathy). These symptoms are not severe in most cases, and usually resolve within 24 hours. Side effects should be reported to your medical provider. Certain severe allergic reactions have been reported; if you develop symptoms of an allergic reaction following vaccination (such as trouble breathing, chest pain or a fast heartbeat, dizziness, weakness, swelling of the face, throat, or tongue, or a rash all over your body), **call 911 or go to the nearest Hospital Emergency Department.**

**Emergency Use Authorization**

The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

**Consent**

I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any money or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/money from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.



| Initial |
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Please respond to the following questions to determine eligibility for vaccination.

| Screening Questionnaire | | | | |
|---|---|---|---|---|
| 1. | Are you feeling sick today including having fever? | [ ] Yes | [ ] No | [ ] Unknown |
| 2. | Have you had a positive COVID-19 test in the last 90 days and received convalescent plasma? | [ ] Yes | [ ] No | [ ] Unknown |
| 3. | Have you received any vaccinations in the past two weeks and/or have you received any other COVID-19 vaccine at any time? | [ ] Yes | [ ] No | [ ] Unknown |
| 4. | Do you have a history of an anaphylactic reaction to anything other than a vaccine or injectable medication (such as a reaction to food, insect stings, or oral medication)? | [ ] Yes | [ ] No | [ ] Unknown |
| 5. | Do you have an adrenaline auto injector (EpiPen) for severe allergic reactions? | [ ] Yes | [ ] No | [ ] Unknown |
| 6. | Have you ever had a serious reaction after receiving a vaccination or IV injectable medications? | [ ] Yes | [ ] No | [ ] Unknown |
| 7. | Are you currently receiving anticoagulation therapy, or do you have any type of bleeding disorder? | [ ] Yes | [ ] No | [ ] Unknown |
| 8. | Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system? | [ ] Yes | [ ] No | [ ] Unknown |
| 9. | Do you, anyone you live with or take care of, take steroids, anticancer drugs or x-ray treatments? | [ ] Yes | [ ] No | [ ] Unknown |
| 10. | Is it possible that you are or may become pregnant in the next four weeks? | [ ] Yes | [ ] No | [ ] Unknown |
| 11. | Are you currently breastfeeding? | [ ] Yes | [ ] No | [ ] Unknown |

If you answered "Yes" to any of the questions 1 to 3, you should not have the COVID-19 Vaccine today:

- If you are sick, we recommend you delay vaccination until your symptoms have resolved. If you are diagnosed with COVID-19 you should delay the vaccination for 90 days after diagnosis.
- If you have received other vaccinations recently for something other than COVID-19, it is recommended that you wait 2 weeks following that vaccine(s) prior to receiving the COVID-19 Vaccine.
- If you have received a different COVID-19 vaccine, you should not receive the new COVID-19 Vaccine as there is no data on safety or efficacy of combining vaccines from different manufacturers. If you were vaccinated as part of a clinical trial, you should contact the research team with any questions or concerns
- about receiving new COVID-19 Vaccine.
- If you have been diagnosed with COVID-19 at any time within the past 90 days, we recommend waiting 90 days from your diagnosis before getting the new COVID-19 Vaccine.
- • If you have a history of anaphylaxis to any of the ingredients in the Moderna Vaccine, you should not receive the CPVID-19 Vaccine at any time, based on current guidance.

______________________________________________________________

**Recipient/Surrogate (Signature)** **Date / Time** **Name** **Relationship to Recipient**

**Area Below to be Completed by Vaccinator**

| Vaccine Name | Administration | | MFG | Lot No. | Expiration Date |
|---|---|---|---|---|---|
| | First Dose | Second Dose | | | |
| | | | | | |

| Administration Site | Left Deltoid | Right Deltoid |
|---|---|---|
| Dosage | | |

**Vaccinator Signature:** ______________________________ **Date:** ____________________