

# Warm Springs Medical Center's COVID-19 Vaccine Consent Form

**Qualifications:**

- 55+ years old
- Employee  HCW
- Law Enforcement
- Caregiver of \_\_\_\_\_ (Age: \_\_\_\_\_)
- Shot given to prevent dose wastage

**Section 1: Patient/Employee Information**

NAME (Last)		(First)	DATE OF BIRTH	GENDER
ADDRESS				
CITY	STATE	ZIP	DAYTIME PHONE NUMBER	
PRIMARY CARE PHYSICIAN: Name		Address		Phone Number
EMERGENCY CONTACT: Name		Relation	Phone Number	

**IS THIS YOUR  FIRST OR  SECOND DOSE OF THE COVID-19 VACCINE?**

- If this is your second dose, what was the date of your first dose? \_\_\_\_\_
- Which vaccine did you receive?  Pfizer  Moderna  Other

**Section 2: Screening Questions**

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. If you answer “yes” to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your health care provider to explain it.

	YES	NO	Don't Know
1. Are you feeling sick today? (For example, cold, fever, or acute illness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any allergies? Please list:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Was the severe allergic reaction after receiving a COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you received another vaccine in the last 14 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have a bleeding disorder or are you on a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you pregnant or plan to become pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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## Section 3: Consent

I have been given a copy and have read, or have had explained to me, the information in the **FACT SHEET** for the COVID-19 vaccine. I understand the FDA has authorized the emergency use of the COVID-19 vaccine, which is not an FDA-approved vaccine. I have had the chance to ask questions that were answered to my satisfaction.

I have reviewed the Georgia Department of Public Health's list of groups who are currently eligible to receive the COVID-19 vaccine in Georgia, and I am currently eligible to receive the COVID-19 vaccine.

I understand the COVID-19 vaccine requires two (2) doses. If this is my first dose of the COVID-19 vaccine, I intend to receive a second dose of the same vaccine in accordance with the timeframe specified in the Fact Sheet to complete the vaccination series.

I understand the significant known and potential risks and benefits of the COVID-19 vaccine as explained in the **FACT SHEET** and that some potential risks and benefits may remain unknown, and **I REQUEST THE COVID-19 VACCINE BE GIVEN TO ME.**

I agree to stay in the vaccine administration area for fifteen (15) minutes (or longer if indicated by the vaccine administrator) after receiving my vaccination to ensure that no immediate adverse reactions occur, and I understand that if I experience any adverse reaction, it will be my responsibility to follow up with my primary care physician.

**SIGNATURE OF PATIENT / EMPLOYEE / LEGAL REPRESENTATIVE:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** (if applicable) \_\_\_\_\_ **DATE:** \_\_\_\_\_

## Section 5: Vaccination Record

### FOR ADMINISTRATIVE USE ONLY

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	_____ml <input type="checkbox"/> 1 <sup>st</sup>	↑IM - L Arm					
	_____ml <input type="checkbox"/> 2 <sup>nd</sup>	↑IM - R Arm					