GEORGIA DEPARTMENT OF PUBLIC HEALTH

Pfizer COVID-19 Vaccine

COVID-19 VACCINE INFORMATION AND CONSENT FORM

NAME (Last)	(First)	Date of Birth: _____/_____/_____	Age:
ADDRESS			
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 and the date administered: ☐ Pfizer _____ ☐ Moderna _____ ☐ Another Product _____			
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?			
*Was the severe reaction after receiving a COVID-19 vaccine?			
*Was the severe reaction after receiving another vaccine or another injectable medication?			
4. Have you received another vaccine in the last 14 days?			
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
6. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
7. Do you have a bleeding disorder or are you taking a blood thinner?			
8. Are you pregnant or breastfeeding?			

I have been given a copy and have read the Emergency Use Authorization (EUA) and reviewed the FDA Fact Sheet for Recipients and Caregivers (https://www.fda.gov/media/144414/download) prior to receiving the COVID-19 vaccine. 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	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	_____ml ☐ 1st _____ml ☐ 2nd	IM - L Arm IM - R Arm					