GEORGIA DEPARTMENT OF PUBLIC HEALTH

COVID-19 Vaccine
INFORMATION AND CONSENT FORM

NAME (Last)	(First)	Date of Birth: _____/_____/_____	**Age:**
ADDRESS		**EMAIL**	
CITY	**STATE** **ZIP**	**DAYTIME PHONE NUMBER**	
EMERGENCY CONTACT: **Name**	**Relation**	**Phone Number**	

Insurance: _____ **Member ID:** _____

Race: (check only 1) ☐Asian/Polynesian ☐Black ☐Multiracial ☐Native Am/Alaskan ☐White ☐Unknown	**Ethnicity: (check only 1)** ☐ Not Hispanic ☐ Hispanic ☐Unknown	**Primary Language:** ☐ English ☐Other _____	**Gender:** ☐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: ☐ 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
☐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
☐Have a weakened immune system (i.e., HIV infection, cancer): If yes list condition:_____
☐Take immunosuppressive drugs or therapies: If yes please list: _____
☐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

I have accessed and read the Pfizer Emergency Use Authorization (EUA)
_____ Pfizer (age 12 & over)
I have called the Washington County Health Department and 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

I give consent for my child to be vaccinated at Washington County Schools, without a parent present.

_____ _____ **X**_____
Date **Print Name** **Patient or Parent/Guardian Signature**

FOR ADMINISTRATIVE USE ONLY

Vaccine recipient provided:
☐ Pfizer https://www.fda.gov/media/144414/download

Vaccine	Dose	Route	Date Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID -19	_____ml ☐ 1st _____ml ☐ 2nd _____ml ☐ 3rd	☐ IM - L Arm ☐ IM - R Arm		Pfizer			