Upson Regional Medical Center's COVID-19 Vaccine Consent Form

Section 1: Patient/Employee Information

NAME (Last)	(First)	**DATE OF BIRTH**	**GENDER**

ETHNICITY: □ Hispanic or Latino □ Not Hispanic or Latino	**RACE:** □ African American □ Caucasian □ Asian □ Hispanic or Latino □ Native Hawaiian or Pacific Islander □ American Indian or Alaska Native □ Other _____ □ Unknown

STREET 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? ____/____/_____**
- **If this is your second dose which vaccine did you receive as your first dose?**
  □ Pfizer □ Moderna □ Janssen (Johnson & Johnson) □ Other _____

Section 2: 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 □ 1st _____ml □ 2nd	IM - L Arm IM - R Arm					

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Section 3: 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)	☐	☐	☐
2. Do you have any allergies? Please list:	☐	☐	☐
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 allergic reaction after receiving a COVID-19 vaccine?	☐	☐	☐
• Was the severe allergic reaction after receiving another vaccine or another injectable medication?	☐	☐	☐
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
5. Have you received another vaccine in the last 14 days?	☐	☐	☐
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
7. Do you have a bleeding disorder or are you on a blood thinner? If yes, please list: _____	☐	☐	☐
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?	☐	☐	☐
9. Are you pregnant or plan to become pregnant?	☐	☐	☐
10. Are you breastfeeding?	☐	☐	☐

Section 4: 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 understand the COVID-19 vaccine may require two (2) doses. If this is my first dose of the Pfizer or Moderna 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 VACCINE RECIPIENT OR LEGAL REPRESENTATIVE: _____

PRINTED NAME OF VACCINE RECIPIENT OR LEGAL REPRESENTATIVE: _____

RELATIONSHIP TO VACCINE RECIPIENT: (if applicable) _____**DATE:** ___/_____/_____