UPSON Regional Medical Center

COVID-19 Vaccine
INFORMATION AND CONSENT FORM

NAME (Last)	(First) (Middle Initial)	**MAIDEN NAME, If Female**	**Age:**
ADDRESS		**DATE OF BIRTH:** _____/_____/_____	
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: ☐ 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
☐ 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
☐ Had COVID-19 and was treated with **monoclonal antibodies or convalescent serum.** Date of treatment: _____
☐ Diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection

5. Check **all** that apply to you:
☐ Have a weakened immune system (i.e., HIV infection, cancer): If yes list condition: _____
☐ Take immunosuppressive drugs or therapies: If yes please list: _____

I have been given a copy and have read the Emergency Use Authorization (EUA) and reviewed the FDA Fact Sheet for the Recipients and Caregivers for the COVID-19 vaccine product I will be administered (choose one of the following):
☐ Pfizer (age 5 through 11) ☐ Pfizer (age 12 & over)

I have had the chance to ask questions and my questions 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 recipient provided:

☐ Pfizer (age 12 and over): https://www.fda.gov/media/153716/download
☐ Pfizer (age 5 through 11): https://www.fda.gov/media/153717/download

Vaccine	Dose	Route	Date Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	_____ml ☐ 1st _____ml ☐ 2nd _____ml ☐ 3rd _____ml ☐ 4th	☐ IM - L Arm ☐ IM - R Arm ☐ IM – L Leg ☐ IM - R Leg					