COVID-19 VACCINE CONSENT

Name: ________________________________ Employee ID #________________

Address: ____

City: ___________________State: ______ Zip: __________Tel#_______________

D.O.B. ______________________Height: _______________Weight:_____________

Mother's First Name: __________Mother's Maiden Name: ____________________

Emergency Contact Name: _____________________ Relation: ________________

Emergency Contact Number: ____________________________

IS THIS YOUR ☐ FIRST, ☐ SECOND OR ☐ THIRD (booster) DOSE OF THE COVID-19 VACCINE?

- **If this is your second or third dose, what were the dates of your previous doses? 1st __________2nd ___________**
- **Which vaccine did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Other**

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.

Screening Questions: Please use the back of this form if extra space is needed	YES	NO	NOT SURE
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 to polyethylene glycol (PEG) or polysorbate or did it occur after receiving another vaccine or injectable medication?			
4. Have you ever had myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside the heart)?	☐	☐	☐
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
6. Have you received another vaccine in the last 14 days?	☐	☐	☐
7. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID19?	☐	☐	☐
8. Do you have a bleeding disorder or are you on a blood thinner?	☐	☐	☐
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
10. Are you pregnant or plan to become pregnant?	☐	☐	☐
11. Are you breastfeeding?	☐	☐	☐
12. Do you have dermal fillers?	☐	☐	☐
13. Have you ever fainted in association with an injection?	☐	☐	☐

☐ 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.**

☐ I consent to the release of my Covid-19 vaccine status, including any supporting documentation, to all such representatives of SGMC on a need-to-know basis in order for the representatives to carry out their duties and to act on my request for a vaccine and for the purpose of healthcare operations.

Complete this section only if you are receiving a third dose (booster) of the COVID-19 vaccine.

☐ I understand a third dose (booster) of the COVID-19 vaccine is authorized and recommended for moderately to severely immunocompromised individuals who initially received the Pfizer or Moderna COVID-19 vaccine. I am eligible to receive a third dose (booster) of the COVID-19 vaccine because I have:

- Been receiving active cancer treatment for tumors or cancers of the blood.
- Received an organ transplant and am taking medicine to suppress my immune system.
- Received a stem cell transplant within the last 2 years or am taking medicine to suppress my immune system.
- Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome).
- Advanced or untreated HIV infection.
- Active treatment with high-dose corticosteroids or other drugs that may suppress my immune response.
- Another medical condition that causes my immune system to be moderately to severely compromised and for which my treating physician recommends I receive a third dose (booster) of the COVID-19 vaccine

PATIENT SIGNATURE/LEGAL REPRESENTATIVE: ______________________________________

RELATIONSHIP TO PATIENT: (if applicable) _______________________ **DATE**: ______________

FIRST DOSE ADMINISTRATION OF VACCINE				
Date given	Injection Site	Nurse Signature	License #	
	☐ **LD** ☐ **RD**			
Prophylactic Acetaminophen 325mg tab x 2 PO dose given: ☐Yes ☐ No Lot# / Exp:				
Covid-19 vaccine: ☐ **Pfizer Covid-19 Vaccine** ☐ **Moderna Covid-19 Vaccine** Lot # / Exp:				
Date/Time of Dose 2: **ENTERED INTO BOOKINGS** ☐				

SECOND DOSE ADMINISTRATION OF VACCINE				
Date given	Injection Site	Nurse Signature	License #	
	☐ **LD** ☐ **RD**			
Prophylactic Acetaminophen 325mg tab x 2 PO dose given: ☐Yes ☐ No Lot# / Exp:				
Covid-19 vaccine: ☐ **Pfizer Covid-19 Vaccine** ☐ **Moderna Covid-19 Vaccine** Lot # / Exp:				

THIRD DOSE ADMINISTRATION OF VACCINE				
Date given	Injection Site	Nurse Signature	License #	
	☐ **LD** ☐ **RD**			
Prophylactic Acetaminophen 325mg tab x 2 PO dose given: ☐Yes ☐ No Lot# / Exp:				
Covid-19 vaccine: ☐ **Pfizer Covid-19 Vaccine** ☐ **Moderna Covid-19 Vaccine** Lot # / Exp:				

GRITS________API_______ Cost Center___________

COUNT__________ **GRITS________API_______**