

- SGHS Team Member / Volunteer
- Patient



**SOUTHEAST GEORGIA
HEALTH SYSTEM**

FIN #: _____

COVID-19 VACCINE INFORMATION AND CONSENT FORM

Section 1: Patient/Employee Information

Name: _____		
Last	First	Middle
Date of Birth: _____		SSN: _____
Address: _____		City/State/Zip _____
Telephone: (_____) _____ - _____		Employee # _____ (if applicable)
*Insurance Plan: _____		Insurance Plan ID: _____

**Patient will not be billed or held responsible for the cost of the COVID-19 vaccine*

THIS IS MY FIRST, SECOND OR THIRD/BOOSTER DOSE OF THE COVID-19 VACCINE.

- **If this is your second, third, or booster dose, what were the dates of your previous doses?**
 1st _____ 2nd _____ 3rd _____
- **Which vaccine did you receive?** Pfizer Moderna Janssen (Johnson & Johnson) Other

Section 2: Screening Questions

Please answer the health questions below:	Yes	No	Not Sure
1. Are you sick today or currently in an isolation period for COVID-19?			
2. Have you had a positive COVID-19 test in the last 90 days and received convalescent plasma or passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
3. Are you allergic to anything, including any food, any vaccine, any vaccine component, latex, or polyethylene glycol?			
4. Have you ever had myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside the heart)?			
5. Have you received any vaccinations in the past two weeks?			
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
7. Are you currently receiving anticoagulation (blood thinner) therapy or do you have any type of bleeding disorder?			
8. Do you, anyone you live with or take care of, have a weakened immune system?			
9. Have you had an organ or bone marrow transplant?			
10. Is it possible that you are or may become pregnant in the next four weeks?			
11. Are you breastfeeding?			
12. Do you have dermal fillers?			
13. Have you ever fainted in association with an injection?			

Section 3: Eligibility and Consent

I've received a copy and have read, or have had explained to me, the information in the COVID-19 vaccine **FACT SHEET**. I understand the Pfizer COVID-19 vaccine is FDA-approved for ages 16 and up and that the FDA has authorized the emergency use of the Pfizer COVID-19 vaccine for children 12-15 and the Moderna COVID-19 vaccine for adults. I have had the chance to ask questions that were answered to my satisfaction.

I understand the COVID-19 vaccine may require multiple doses or a booster. 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 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.**

I'll stay in the vaccine administration area for 15 minutes (or longer if indicated by my 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.

Additional Consent for Third/Booster Dose Only. I understand a third or booster dose of the COVID-19 vaccine is authorized and recommended for some people. I'm eligible to receive a third or booster dose because:

I'm a moderately to severely immunocompromised individual with one or more of the following conditions who initially received the Pfizer or Moderna COVID-19 vaccine.

- 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.
- Have moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome).
- Have advanced or untreated HIV infection.
- Am in active treatment with high-dose corticosteroids or other drugs that may suppress my immune response.
- Have 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 of the COVID-19 vaccine.

I've completed the primary series of the Pfizer COVID-19 vaccine at least 6 months ago **and** I'm either:

- Age 65 or older.
- A resident in a long-term care setting.
- Age 50 to 64 with a history of cancer, chronic kidney disease, chronic lung diseases, dementia or other neurological conditions, diabetes, Down syndrome, heart conditions, HIV, liver disease, pregnancy, sickle cell disease, thalassemia, history of smoking, stroke, history of substance abuse.
- Age 18 to 49 and at high risk for severe COVID-19 based on individual risks associated with a history of cancer, chronic kidney disease, chronic lung diseases, dementia or other neurological conditions, diabetes, Down syndrome, heart conditions, HIV, liver disease, pregnancy, sickle cell disease, thalassemia, history of smoking, stroke, history of substance abuse.
- Age 18 to 64 with an increased risk of COVID-19 exposure and transmission due to my occupational or institutional setting for whom the booster is recommended based on individual benefits and risks (e.g., healthcare workers).

Section 4: Signature

Signature of Patient, Team Member, or Guardian: _____

Relationship to Patient: (if applicable) _____ Date: _____

Section 5: Vaccination Record

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Date	Manf	Lot #	Exp	Dose	Route	Site	VIS	Nurse

