☐ SGHS Team Member / Volunteer
☐ Patient

SOUTHEAST GEORGIA
HEALTH SYSTEM

FIN #: _____

FOR INDIVIDUALS 12 YEARS OLD OR OLDER

COVID-19 VACCINE INFORMATION AND CONSENT FORM

Section 1: Demographic Information

Name: _____ _____ _____
Last First Middle

Date of Birth: _____ **Age:** _____ **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, ☐ THIRD, OR ☐ BOOSTER DOSE OF THE COVID-19 VACCINE.

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

Section 2: Screening Questions

Please answer the health questions below for the individual receiving the vaccine:	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 tested positive 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 a 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?			
14. Are you age 12 or older?			

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 monovalent Pfizer COVID-19 vaccine is FDA-approved for ages 16 and up and that the FDA has authorized the emergency use of the monovalent Pfizer COVID-19 vaccine for children 5-15 and the monovalent Moderna COVID-19 vaccines for adults. I also understand that the FDA has authorized the emergency use of the bivalent Pfizer COVID-19 booster for ages 12 and up and the bivalent Moderna COVID-19 booster 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. I intend to receive all recommended doses 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 Dose (Immunocompromised Recipients ONLY): I understand a third dose of the COVID-19 vaccine is authorized and recommended for some people. I'm eligible to receive a third dose because:

☐ I'm 12 years old or older and getting a third dose of the Pfizer vaccine **OR** 18 years or older and getting a third dose of the Moderna vaccine; **AND**
☐ I'm moderately to severely immunocompromised[1] and initially received the Pfizer or Moderna COVID-19 vaccine.

Additional Consent for Booster Doses (Booster Recipients ONLY): I understand a booster dose of the COVID-19 vaccine is authorized and recommended for some people.

If this is a booster dose:
☐ I'm eligible to receive a booster dose of the **bivalent Pfizer COVID-19 booster** because (i) I completed primary series of all COVID-19 doses at least 2 months ago, (ii) I have not yet received a booster dose or it has been at least 2 months since my last booster dose, and (iii) I'm **12 years old or older**.
☐ I'm eligible to receive a booster dose of the **bivalent Moderna COVID-19 booster** because (i) I completed primary series of all COVID-19 doses at least 2 months ago, (ii) I have not yet received a booster dose or it has been at least 2 months since my last booster dose, and (iii) I'm **18 years old or older**.

Section 4: Signature

Signature of Patient, Team Member, or Guardian: _____

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

Section 5: Vaccination Record **FOR OFFICE USE ONLY**

Date	Manf	Lot #	Exp	Dose	Route	Site	VIS	Nurse
	Moderna	A57144B	05/12/23	0. 5	IM			

[1] Immunocompromised means that you: (1) have been receiving active cancer treatment for tumors or cancers of the blood; (2) received an organ transplant and are taking medicine to suppress your immune system; (3) received a stem cell transplant within the last 2 years or are taking medicine to suppress your immune system; (4) have moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome, etc.); (5) have advanced or untreated HIV infection; (6) are in active treatment with high-dose corticosteroids or other drugs that may suppress your immune response; or (7) have another medical condition that causes my immune system to be moderately to severely compromised and for which your treating physician recommends you receive a third dose or additional booster dose of the COVID-19 vaccine.

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Section 5: Vaccination Record

FOR OFFICE USE ONLY

Date	Manf	Lot #	Exp	Dose	Route	Site	VIS	Nurse
	Pfizer	GH9702	06/30/23	0.3	IM			

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