GSW
GEORGIA SOUTHWESTERN STATE UNIVERSITY

COVID-19 Vaccine
INFORMATION AND CONSENT FORM

NAME (Last)	(First)	Date of Birth: / /	**Age:**
ADDRESS		**COUNTY OF RESIDENCE**	
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, vaccine product and the date administered: _____			
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 reaction after receiving a COVID-19 vaccine?			
*Was the severe reaction after receiving another vaccine or another injectable medication?			
4. Have you received another vaccine in the last 14 days?			
5. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
6. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
7. Do you have a bleeding disorder or are you taking a blood thinner?			
8. Are you pregnant or breastfeeding?			

I have been given a copy and have read the Emergency Use Authorization (EUA) and reviewed the FDA Fact Sheet for Recipients and Caregivers for the COVID-19 vaccine product I will be administered (choose one of the following): _____ Pfizer (age 16 & over); _____ Moderna (age 18 and over); _____ Janssen (age 18 and over). I have had the chance to ask questions that 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 https://www.fda.gov/media/144414/download
Moderna https://www.modernatx.com/covid19vaccine-eua/eua-fact-sheet-recipients.pdf
Janssen https://www.janssenlabels.com/emergency-use-authorization/Janssen+COVID-19+Vaccine-Recipient-fact-sheet.pdf

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