YOURTOWN HEALTH

COVID-19 Vaccine Consent Form

Ssection 1: Personal Information

NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH** month_____day_____ year_____
PHONE NUMBER	**CELL PHONE NUMBER**		**AGE** / **GENDER** Male / Female
ADDRESS			**EMAIL ADDRESS**
CITY	**STATE**	**ZIP**	
RACE:			**ETHNICITY:** NON-HISPANIC HISPANIC

Section 2: Screening for Vaccine Eligibility

	YES	NO
1. Are you feeling sick today?	☐	☐
2. Have you ever received a dose of COVID-19 Vaccine? Name _____	☐	☐
3. Have you ever had an allergic reaction to: a. A component of a COVID-19 vaccine including either Polyethylene glycol or Polysorbate. b. A previous dose of Covid-19 Vaccine c. A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not know which component elicited the immediate reaction. (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling or respiratory distress, including wheezing)	☐	☐
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing)	☐	☐
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a Vaccine, this would include food, pet, venom, environmental or oral medication allergies.	☐	☐
6. Have you received any vaccine in the last 14 days?	☐	☐
7. Have you ever had a positive test for COID-19 or has a doctor ever told you that you had COVID-19? When?	☐	☐
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐
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. Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐
11. Are you pregnant or breastfeeding?	☐	☐
12. Do you have dermal fillers?	☐	☐

CONSENT FOR VACCINATION:

I have read or had explained to me the COVID-19 Vaccine EUA Fact Sheet for Recipients for the vaccine and understand the risks and benefits. I give consent to YourTown Health and its staff to be vaccinated with this COVID-19 vaccine.

Signature of Patient or Parent/Guardian _____ Date: _____

Permission to release vaccine information to the Georgia Registry of Immunizations. Initials _____

Section 3: Vaccination Record (FOR ADMINSTRATIVE USE ONLY)

Vaccine	Date Dose Administered	Route/Location	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
COVID-19		IM ____Deltoid	1st	Moderna		YourTown Health
COVID-19		IM ____Deltoid	2nd	Moderna		YourTown Health
COVID-19		IM _____Deltoid	Single Dose	Janssen		YourTown Health