COVID-19 VACCINE CONSENT FORM

Name: _____ SGMC Employee ID (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

DOB: _____)____ Height: _____ Weight: _____

Mother's First Name: _____

Mother's Maiden Name: _____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Number: _____

ALLERGIES : _____

	YES	NO
1. Are you sick today? (For example: cold, fever, or acute illness)	☐	☐
2. Do you have a bleeding disorder or are you on a blood thinner?	☐	☐
3. Are you immunocompromised or are you on a medication that affects your immune system?	☐	☐
4. Are you pregnant, planning to become pregnant, or breastfeeding?	☐	☐
5. Have you received another COVID-19 vaccine?	☐	☐
6. Have you every had a serious reaction to any vaccine that required medical care? If yes, describe: _____	☐	☐
7. Have you received any other vaccine in the last 14 days?	☐	☐
8. Have you tested positive for COVID-19 within the past 14 days?	☐	☐

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 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 and agree to release South Georgia Health System from any liability which might result from this immunization.
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.
I understand the COVID-19 vaccine requires 2 doses. If this is my first dose of the 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 agree to get my second dose of vaccine from SGMC.
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 have reviewed the Georgia Department of Public Health's list of groups who are currently eligible to receive the COVID-19 vaccine in Georgia, and I am currently eligible to receive the COVID-19 vaccine.

_____ _____

Patient Signature **Date**

DO NOT fill out the portion below. SGMC USE ONLY

SGMC COVID-19 VACCINE DOCUMENTATION

2501 North Patterson Street, Valdosta, GA 31602 | 229-259-4715

Dispense: ☐ Pfizer COVID-19 Vaccine ☐ Moderna COVID-19 Vaccine

Sig: One intramuscular injection of a 2-dose series to be administered.

Patients receiving either COVID-19 vaccine will receive 2 doses.

- Pfizer vaccine is administered 21 days apart
- Moderna vaccine is administered 28 days apart

Ordered within the scope of the FDA Emergency Use of Authorization approval.

Initials of Pharmacist
Reviewing Information: _____ Date: _____

Notes: _____

FIRST DOSE OF ADMINISTRATION OF VACCINE

Date Given	Injection Site	Nurse Signature	License #
	☐ LD ☐ RD		

COVID-19 Vaccine: ☐ Pfizer COVID-19 Vaccine ☐ Moderna COVID-19 Vaccine

Lot #/ Exp:

Acetaminophen 325mg tab x 2 PO dose given: ☐ Yes ☐ No

Lot #/ Exp:

DATE/TIME FOR DOSE 2:

SECOND DOSE OF ADMINISTRATION OF VACCINE

Date Given	Injection Site	Nurse Signature	License #
	☐ LD ☐ RD		

COVID-19 Vaccine: ☐ Pfizer COVID-19 Vaccine ☐ Moderna COVID-19 Vaccine

Lot #/ Exp:

Acetaminophen 325mg tab x 2 PO dose given: ☐ Yes ☐ No

Lot #/ Exp:

LD= LEFT DELTOID RD= RIGHT DELTOID

COUNT _____ **GRITS** _____ **API** _____ **COST CENTER** _____