Georgia Department of Public Health
Coastal Health District

COVID-19 VACCINE INFORMATION AND CONSENT FORM

Name: _____ _____ _____
First Middle Last

Address: _____ _____ _____ _____
Street City State Zip

Telephone: (_____) _____--_____ _____
SSN

Date of Birth: _____--_____--_____	Age:	**Gender:** ☐Male ☐ Female	**Primary Language:** ☐ English ☐Other _____	**Ethnicity: (check only 1)** ☐ Not Hispanic ☐ Hispanic ☐ Unknown

Race: (check only 1) ☐Asian/Polynesian ☐Black ☐Multiracial ☐White ☐Native Am/Alaskan ☐Unknown

Please answer the health questions below:	**Yes**	**No**	**Don't Know**
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?			
3. Are you allergic to anything including any food, any vaccine, any vaccine component, latex, or polyethylene glycol?			
4. Do you have an adrenaline auto injector (EpiPen) for severe allergic reactions?			
5. Have you ever had a serious reaction after receiving a vaccination or IV injectable medications?			
6. Have you received any vaccinations in the past two weeks?			
7. Are you currently receiving anticoagulation 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. Do you, anyone you live with or take care of, take steroids, anti-cancer drugs or x-ray treatments?			
10. Is it possible that you are or may become pregnant in the next four weeks?			
11. Are you currently breastfeeding?			

I have been given a copy and have read, or have had explained to me, the information in the Vaccine Information Statements for the vaccines indicated. I have had the chance to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of the vaccines requested and ask that the vaccines indicated be given to me or the person named for whom I am authorized to make this request.

It is suggested that anyone getting a vaccine stay for 15 minutes after getting vaccinated before leaving.
Those with previous anaphylactic reactions should stay for 30 minutes.

_____ _____ **X**_____
Date **Print Name** **Patient/Guardian Signature**

OFFICE USE ONLY	**Record of Immunization**						**OFFICE USE ONLY**	
	Vacc							
	Manf	**Lot #**	**Exp**	**Dsg**	**Rte**	**Ste**	**VIS**	**Nurse**

Date of Vaccination: _____

Revised December 2020