

COVID-19 Vaccine Consent Form

Section 1: Patient/Employee Information

NAME (Last)	(First)	DATE OF BIRTH	GENDER
ADDRESS			
CITY	STATE	ZIP	DAYTIME PHONE NUMBER
PRIMARY CARE PHYSICIAN: Name		Address	Phone Number
EMERGENCY CONTACT: Name		Relation	Phone Number

IS THIS YOUR **FIRST** OR **SECOND** DOSE OF THE COVID-19 VACCINE? If this is your second dose, what was the date of your first dose? _____

Section 2: Screening Questions

	YES	NO
1. Do you have any allergies? Please list:	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you sick today? (For example, cold, fever, or acute illness)	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a bleeding disorder or are you on a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you immunocompromised or are you on a medicine that affects your immune system?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you pregnant or plan to become pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you received another COVID-19 vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

Section 3: Consent

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 COVID-19 vaccine requires 2 doses given 3 weeks apart. 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 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.**

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.

SIGNATURE OF PATIENT / EMPLOYEE / LEGAL REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT (if applicable) _____ **DATE:** _____

Section 5: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	_____ ml <input type="checkbox"/> 1 st _____ ml <input type="checkbox"/> 2 nd	<input type="checkbox"/> IM - L Arm <input type="checkbox"/> IM - R Arm					

ABOUT THIS FORM:

- This Template COVID-19 Vaccine Consent Form was created by the Georgia Hospital Association as a resource for its member hospitals. It is not a mandatory form.
- ***This form should only be provided to a patient if it is accompanied by the Fact Sheet for Vaccine Recipients and Caregivers available at <https://www.cvdvaccine.com/> or <https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine>.***
- This form should only be used by clinicians well versed in the CDC's provider education materials who are able to counsel patients who answer "yes" to the screening questions or make referrals for counseling for those patients.
- Organizations and individuals choosing to use this form should do so in consultation with their own clinical experts, legal counsel and risk managers. This form is being provided for informational purposes only and is not legal advice.
- This form was developed based on the best available information at the time it was created. Its accuracy is not guaranteed. ***This form is subject to update without notice and will likely require updates upon the FDA's emergency use authorization or approval of additional COVID-19 vaccines.***
- Resources used in creating this form:
 - [FDA Emergency Use Authorization of Pfizer-BioNTech COVID-19 Vaccine](#)
 - [Fact Sheet for Vaccine Recipients and Caregivers of EUA Pfizer-BioNTech COVID-19 Vaccine](#)
 - [Fact Sheet for Healthcare Providers Administering Vaccine of EUA Pfizer-BioNTech COVID-19 Vaccine](#)
 - [CDC COVID-19 Vaccination Training Programs and Reference Materials for Healthcare Professionals](#)