TIFT REGIONAL HEALTH SYSTEM
COVID VACCINE SCREENING AND CONSENT FOR VACCINATION

Patient Information

NAME (Last)	(First)	**DATE OF BIRTH**	**GENDER**
ADDRESS			
CITY	**STATE**	**ZIP**	**DAYTIME PHONE NUMBER**
ETHNICITY □ Hispanic or Latino □ Not Hispanic or Latino	**RACE** □ Asian □ Black or African American □ Hispanic or Latino □ White □ Other □ American Indian or Alaskan Native □ Native Hawaiian or Other Pacific Islander		
PRIMARY CARE PHYSICIAN: **Name**	**Address**		**Phone Number**
EMERGENCY CONTACT: **Name**	**Relation**	**Date of Birth**	**Phone Number**

COVID-19 Screening Questions	Yes	No	Don't Know
1. Have you tested positive for COVID-19 or are you currently being monitored for COVID-19 in quarantined?	◯	◯	◯
2. Have you had prolonged contact with anyone who tested positive for COVID-19 without personal protective equipment?	◯	◯	◯
3. Have you had the new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting, or diarrhea?	◯	◯	◯

Vaccination Screening Questions	Yes	No	Don't Know
1. 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 allergic reaction after receiving a COVID-19 vaccine?	◯	◯	◯
• Was the severe allergic reaction to polyethylene glycol (PEG) or polysobate or did it occur after receiving another vaccine or injectable medication?	◯	◯	◯
2. Have you ever had myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside the heart)?	◯	◯	◯
3. Has a physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	◯	◯	◯
4. Have you had or do you have Guillain Barre?	◯	◯	◯
5. Do you take anticoagulation medications (blood thinners, such as Eliquis®, Pradaxa®, Xarelto®, Warfarin, Coumadin®, etc.)?	◯	◯	◯
6. Have you experienced palsy or do you have Bell's Palsy or any other type of palsy?	◯	◯	◯
7. In the past 90 days, have you received any monoclonal antibody therapy for the treatment of COVID-19 (such as Bamlanivimab, Casirivimab/Imdevimab, etc.)?	◯	◯	◯
8. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	◯	◯	◯
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or convalescent plasma containing COVID-19 antibodies?	◯	◯	◯
10. Are you pregnant or considering becoming pregnant during the next month?	◯	◯	◯
11. Are you breastfeeding?	◯	◯	◯
12. Do you have a history of cardiac arrhythmias?	◯	◯	◯
13. Have you received any other vaccines in the last 14 days?	◯	◯	◯
14. Do you have derma fillers?	◯	◯	◯
15. Have you ever fainted in association with an injection?	◯	◯	◯

IS THIS YOUR □ FIRST, □ SECOND OR □ THIRD DOSE OF THE COVID-19 VACCINE?

- **If this is your second or third dose, what was the date of your previous doses? 1st_____ 2nd_____**
- **Which vaccine did you receive? □ Pfizer □ Moderna □ Janssen (Johnson & Johnson) □ Other**

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Last Name First Name Date of Birth

Allergies and Past Vaccine History

1. List allergies or reactions to any foods: _____
Type of reaction was experienced: _____Onset of reaction that was experienced: _____
2. List allergies or reactions to any medications: _____
Type of reaction was experienced: _____Onset of reaction that was experienced: _____
3. List allergies or reactions to past vaccines: _____
Type of reaction was experienced: _____Onset of reaction that was experienced: _____
4. List allergies or reactions to latex: _____
Type of reaction was experienced: _____Onset of reaction that was experienced: _____

Eligibility– Third Dose/Booster

Moderna Booster

□ I am eligible for a booster of the COVID-19 Moderna vaccine as I received the Moderna or Pfizer-BioNTech COVID-19 primary series (two doses) at least **five months prior** AND am 18 years old or older.

Pfizer Booster

□ I am 18 years old or older and I received the Moderna or Pfizer-BioNTech COVID-19 primary series (two doses) at least **five months prior**.

OR

□ I am 12-17 years old and I received the Pfizer-BioNTech COVID-19 primary series (two doses) at least **five months prior.**

Immunocompromised Individual - Third Dose

□ I understand a third dose of the COVID-19 vaccine is authorized and recommended for moderately to severely immunocompromised individuals who initially received the Moderna or Pfizer COVID-19 primary series (two doses) at least **twenty-eight days prior**. I am eligible to receive a third dose of the COVID-19 vaccine because I have an immunocompromised condition.[1]

Consent for Administration of Vaccine

Vaccine: SARS-CoV-19 (COVID-19)

In consideration of the administration of the above-listed vaccine (the "Vaccine") by Tift Regional Health System, Inc. ("TRHS"), I agree and consent as follows:

1. I have been provided with the Vaccine Information Sheet(s) or patient fact sheet corresponding to the Vaccine.
2. I have read the information provided about the Vaccine.
3. I understand the Food and Drug Administration (FDA) approved Pfizer for individuals 12 years of age and older. I understand that the Pfizer vaccine for use in individuals 5 - 15 years of age and for a third dose or booster, Moderna, and Janssen (Johnson & Johnson) is not an FDA-approved vaccine and is authorized by the FDA under an Emergency Use Authorization (EUA). I have had an opportunity to ask questions and any questions I asked were answered to my satisfaction.
4. I understand and acknowledge that TRHS has made no guarantees to me concerning the Vaccine.
5. I understand and recognize that TRHS will maintain documentation of this encounter as part of my medical record.
6. I understand and agrees that TRHS may permit medical, nursing, and other students in health care related fields to participate in and observe care and treatment provided to it patients and that doing so is necessary for teaching purposes. Patient authorizes supervised students to observe and participate in any care or procedure deemed a part of the education process.
7. I agree and acknowledge that certain physician's assistant, nurse practitioners, and other mid-level providers are authorized to provide care, treatment, and services at TRHS.
8. I acknowledge and agree that I have received a copy of the TRHS Notice of Patient Rights and Responsibilities and Notice of Privacy Practices.
9. I understand the significant known and potential risks and benefits of the COVID-19 vaccine as explained in the Vaccine Information (s) or patient fact sheet and that some potential risks and benefits may remain unknown, and **I REQUEST THE COVID-19 VACCINE BE GIVEN TO ME.**
10. I understand that I should remain on site for 15 minutes (or longer if indicated by the vaccine administrator) after the vaccination to be monitored for any potential immediate adverse reaction(s). I understand that if I experience any adverse reaction after leaving the Vaccine administration area, I should call my primary care provider, or call 911.

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11. I understand the COVID-19 vaccine may require two (2) doses. If this is my first dose of the Pfizer or Moderna 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 have been educated to continue to wear personal protective equipment, implement social distancing, and follow CDC guidelines even after I received my Vaccine doses. I hereby certify that I am legally authorized to executed this consent and I hereby consent to and authorize the administration of the Vaccine and authorize TRHS to enter the administration of the Vaccine in the Georgia Registry of Immunizations Transactions and Services (GRITS).

PRINTED NAME OF PATIENT OR PATIENT REPRESENTATIVE	**SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE**
REPRESENTATIVE RELATIONSHIP TO PATIENT (if applicable)	**DATE** **TIME**

Complete the following if an interpreter was utilized:

Name of Interpretation Service	**Name of the Interpreter**

Vaccine Administration Information (to be completed by TRHS)

Validation of Vaccination Status**:** ☐ Vaccination Card ☐ GRITS ☐ Verbal Attestation from Patient/Representative

Administration Date/Time Given	Vaccine/Dose	Manufacturer	EAU/VIS Date	EAU/VIS Date
Lot #	Expiration Date	Route	Site	Volume (mL)
Administering Immunizer Name & Title		Administering Immunizer Signature		Date/Time

GRITS Entered Date: _____ Record Scanned Date: _____