TIFT REGIONAL HEALTH SYSTEM
COVID VACCINE SCREENING AND CONSENT FOR VACCINATION

Patient Information

Last Name	First Name	Date of Birth	Gender	Daytime Phone Number

Address	City	State

Emergency Contact: Name	Relation	Phone Number

Primary Care Physician (PCP) Name	PCP Address	PCP Phone Number

COVID-19 Risk Assessment Questions

Do you have any of the following:	Yes	No	Don't Know
Chronic Lung Disease (emphysema, chronic bronchitis, pulmonary fibrosis, cystic fibrosis, moderate to severe asthma, etc.)	◯	◯	◯
Significant cardiac disease (heart failure, coronary artery disease, congenital heart disease, pulmonary hypertension, etc.)	◯	◯	◯
Obesity (body mass index ≥ 30 kg/m2)	◯	◯	◯
Diabetes (Type 1, Type 2 or gestational)	◯	◯	◯
Liver Disease	◯	◯	◯

Allergies and Past Vaccine History

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

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?	◯	◯	◯

TIFT REGIONAL HEALTH SYSTEM
COVID VACCINE SCREENING AND CONSENT FOR VACCINATION

Last Name First Name Date of Birth

Vaccination Screening Questions	Yes	No	Don't Know
1. Are you sick today? (cold, fever, etc.)	◯	◯	◯
2. Has a physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	◯	◯	◯
3. Have you had or do you have Guillain Barre?	◯	◯	◯
4. Do you take anticoagulation medications (blood thinners, such as Eliquis®, Pradaxa®, Xarelto®, Warfarin, Coumadin®, etc.)?	◯	◯	◯
5. Have you experienced palsy or do you have Bell's Palsy or any other type of palsy?	◯	◯	◯
6. In the past 90 days, have you received any monoclonal antibody therapy for the treatment of COVID-19 (such as Bamlanivimab, Casirivimab/Imdevimab, etc.)?	◯	◯	◯
7. Do you have appendicitis or pain around the belly button to the right lower quadrant of the abdomen or pelvis?	◯	◯	◯
8. Do you have a weakened immune system as a result of a clinical health problem such as cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, etc., or as a result of medications that you are taking that required significant change in therapy or hospitalization for worsening of a stable disease within the past six weeks?	◯	◯	◯
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 breast feeding?	◯	◯	◯
12. Do you have a history of cardiac arrhythmias?	◯	◯	◯
13. Have you received any other vaccines in the last 14 days?	◯	◯	◯

Patient Assessment

Patient Temperature: _____

Is this the patient/employee's First or Second Dose of COVID-19 Vaccination? _____

If second dose, date of first COVID-19 Vaccination: _____

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 that the Vaccine, which is not an FDA-approved vaccine, is authorized by the Food and Drug Administration (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 after the vaccination to be monitored for any potential adverse reaction. I understand that if I experience side effects after leaving the Vaccine administration area, I should call my primary care provider, or call 911.
11. I understand the COVID-19 vaccine requires two (2) doses given three (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 verify that a medical provider, a nurse or a pharmacist asked for my health history and whether I have had a physical exam within the past year. Based on the information I provided and the information identified by the Vaccine's Emergency Use Authorization, health care providers did not identify condition(s) indicating that I should not receive the Vaccine.

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 execute 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

Administration Date/Time	Vaccine	Manufacturer	EAU/VIS Date	EAU/VIS Date Given

Lot #	Expiration Date	Route	Site	Volume (mL)

Administering Immunizer Name & Title

Administering Immunizer Signature Date/Time

GRITS Entered Date: _____

Record Scanned Date: _____