

**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 <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		RACE <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> 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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Have you had prolonged contact with anyone who tested positive for COVID-19 without personal protective equipment?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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: _____

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		
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?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<ul style="list-style-type: none"> • Was the severe allergic reaction after receiving a COVID-19 vaccine? • Was the severe allergic reaction to polyethylene glycol (PEG) or polysorbate or did it occur after receiving another vaccine or injectable medication? 		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Have you ever had myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside the heart)?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Have you had or do you have Guillain Barre?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Do you take anticoagulation medications (blood thinners, such as Eliquis®, Pradaxa®, Xarelto®, Warfarin, Coumadin®, etc.)?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Have you experienced palsy or do you have Bell's Palsy or any other type of palsy?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.)?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Are you pregnant or considering becoming pregnant during the next month?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Are you breastfeeding?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Do you have a history of cardiac arrhythmias?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Have you received any other vaccines in the last 14 days?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Do you have derma fillers?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Have you ever fainted in association with an injection?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Are you either a Georgia resident or a non-resident of Georgia who lives or works in Georgia?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Eligibility– Third Dose

Complete this section only if you are receiving a third dose of the COVID-19 vaccine.

I understand a third dose of the COVID-19 vaccine is authorized and recommended for moderately to severely immunocompromised individuals who initially received the Pfizer and Moderna COVID-19 vaccine. I am eligible to receive a third dose of the COVID-19 vaccine because I have:

- Been receiving active cancer treatment for tumors or cancers of the blood.
- Received an organ transplant and am taking medicine to suppress my immune system.
- Received a stem cell transplant within the last 2 years or am taking medicine to suppress my immune system.
- Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome).
- Advanced or untreated HIV infection.
- Active treatment with high-dose corticosteroids or other drugs that may suppress my immune response.
- Another medical condition that causes my immune system to be moderately to severely compromised and for which my treating physician recommends I receive a third dose of the COVID-19 vaccine.

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 16 years of age and older. I understand that the Pfizer vaccine for use in individuals 12 - 15 years of age and for a third dose in certain immunocompromised

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individuals, 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 agree that TRHS may permit medical, nursing, and other students in health care related fields to participate in and observe care and treatment provided to its 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.
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 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 (to be completed by TRHS)

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

Administration Date/Time Vaccine/Dose 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: _____