

University Cancer & Blood Center, LLC
3320 Old Jefferson Road Bldg 700
Athens, GA 30607

MRN/RX: _____
GRITS ID: _____

COVID-19 VACCINE CONSENT & ADMINISTRATION FORM

NAME:		MOTHER'S MAIDEN NAME:	BIRTHDATE (MM/DD/YY):	
ADDRESS:		CITY:	STATE:	ZIP:
PHONE:		EMAIL:		
ALLERGIES:			GENDER:	

Ethnicity:

Hispanic or Latino Not Hispanic or Latino

Race:

American Indian or Alaskan Native Asian

Native Hawaiian or Other Pacific Islander Hispanic or Latino

White Black or African American

Eligibility:

Age 55 or older Caregiver for 65 or older Long Term Care staff and residents

Healthcare Personnel Law Enforcement, Fire Personnel, First Responders

Educators and Staff Individual with disabilities

Caregiver for Adult with intellectual/developmental disability Parent of child with complex medical conditions

Aged 16 and older with medical conditions that increases risk of severe illness from COVID-19

I consent to receive the COVID-19 Vaccine and am eligible per phase designation notated above. I have received the following: the COVID Vaccine EUA Fact Sheet for recipients and caregivers, the pre-vaccination Checklist for COVID-19 Vaccines, the V-SAFE flyer and have been informed on how to register for the after-vaccination health checker.

Signature of Patient: _____ Signature of Person administering Vaccine; _____

INTERNAL USE ONLY:

Vaccine: Pfizer Moderna	Route/Site: IM Left Arm IM Right Arm	Dose: 1 st 2 nd
DATE/TIME:	LOT:	EXP:
VACCINE ADMINISTRATOR:		