

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

Are you feeling sick today? YES NO	Have you received a vaccine in the last 14 days? YES NO
Have you ever received a dose of COVID-19 vaccine? YES NO	Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19? YES NO
If yes, which vaccine? PFIZER MODERNA JOHNSON & JOHNSON What date? ___/___/_____	Have you ever received a passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? YES NO
Have you ever had an allergic reaction to a previous COVID-19 vaccine or any of its components (polyethylene glycol (PEG) or polysorbate)? YES NO	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies? YES NO
Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? YES NO	Do you have a bleeding disorder or are you taking a blood thinner? YES NO
Have you ever had a severe allergic reaction (e.g., anaphylaxis) to any medication, pet, food, or environmental allergen? YES NO	Are you pregnant or breastfeeding? YES NO

I consent to receive the COVID-19 Vaccine. 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 (Print Name):		