MRN/RX:_____
GRITS ID:_____

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

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:_____

Signature of Parent/Guardian if patient under 18:_____

INTERNAL USE ONLY:

Vaccine: Pfizer Moderna J&J	**Route/Site: IM Left Arm IM Right Arm**	**Dose: 1st 2nd**
DATE/TIME:	**LOT:**	**EXP:**
VACCINE ADMINISTRATOR (Print Name):		