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(s)? Dose 1: ____ /____ /_____ Dose 2: ____ /____ /_____	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**

If this is your 3rd dose of an mRNA vaccine (Pfizer, Moderna), do you meet one of the following eligibility requirements for moderate to severe immunocompromise?

Been receiving active cancer treatment for tumors or cancers of the blood, received an organ transplant and are taking medicine to suppress the immune system, received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system, moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome), advanced or untreated HIV infection, or active treatment with high-dose corticosteroids or other drugs that may suppress your immune response. Individuals 65 years of age and older; individuals 18 through 64 years of age at high risk of severe COVID-19; and individuals 18 through 64 years of age whose frequent institutional or occupational exposure to SARS-CoV-2 puts them at high risk of serious complications of COVID-19 including severe COVID-19. **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 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 3rd**
DATE/TIME:	**LOT:**	**EXP:**
VACCINE ADMINISTRATOR (Print Name):		