## Section 1:
**ELIGIBILITY CRITERIA:**

For patients 16 or 17 years of age,
□ I certify that I am the parent or legal guardian of the patient (i.e., vaccine recipient) and confirm that the patient is at least 16 years of age and meets one or more of the Georgia Department of Public Health defined eligibility criteria to obtain the COVID-19 Vaccine.

## Screening Questions

| | YES | NO | Don't know |
|---|---|---|---|
| **1. Is this your first dose of COVID-19 Vaccine?** | | | |
| **2. Is this your second dose of COVID Vaccine?** | | | |
| **3. If this is your second dose of COVID Vaccine – did you receive Pfizer for your first dose?** | | | |
| **4. If this is your second dose of COVID Vaccine – did you receive Moderna for your first dose?** | | | |
| **5. Are you feeling sick today?** (For example, cold, fever, or acute illness) | | | |
| **6. Did you participate in a COVID-19 Vaccine trial?** | | | |
| **7. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19 in the last 90 days?** | | | |
| **8. Have you ever had an allergic reaction to any COVID-19 Vaccine or to any of the following list of ingredients?**<br><br>In addition to the messenger RNA, the ingredients of the **Pfizer** Vaccine are: 4 different lipids (fats) ((4-hydroxybutyl)azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate), 2[(polyethylene glycol)-2000]- N,N-ditetradecylacetamide, 1,2-distearoyl-sn-glycero-3-phosphocholine, and cholesterol ); potassium chloride; monobasic potassium phosphate; sodium chloride; dibasic sodium phosphate dihydrate; and sucrose.<br><br>In addition to the messenger RNA, the ingredients of the **Moderna** Vaccine are 4 different lipids (SM-102, polyethylene glycol [PEG] 2000 dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose. | | | |
| **9. Do you have a bleeding disorder or do you take a blood thinner?** | | | |
| **10. Is it possible that you are or may become pregnant in the next four weeks, or are you currently breastfeeding?** | | | |
| **11. Have you ever had an anaphylactic reaction (e.g. trouble breathing, broken out in hives, had facial or tongue swelling, had low blood pressure), or had other severe symptoms after receiving another vaccination or an injectable medication (a shot given intravenously, intramuscularly, or subcutaneously)?** | | | |
| **12. Do you have a history of an anaphylactic reaction to anything other than a vaccine or injectable medication** (such as a reaction to food, insect stings, or oral medication)? | | | |
| **13. Do you have a a weakened immune system such as under treatment for lupus, rheumatoid arthritis or cancer?** | | | |

**If you answered "Yes" to any of Questions 5 to 8 , please send a secure message to the COVID Nurse**
**If you answered "Yes" to any of Questions 9 to 12, please send a secure messge to the COVID Assessment Provider**
**If you answered "Yes" to Questions 11, 12, or 13 notify the staff before receiving the COVID-19 Vaccine.**
**If you have a history of anaphylaxis** to something other than the listed ingredients, we will increase your monitoring time after vaccination to make sure there is no evidence of an anaphylactic reaction.

- **If you have either a bleeding disorder or take a blood thinner**, notify the staff at EUSHS so that we can take any necessary precautions.

# COVID-19 Vaccine Consent Form

**If you answered "Yes" to Question 10 or 13:**
You can choose to have the COVID-19 Vaccine with the understanding that there is not yet good data on safety and efficacy of the Vaccine in these groups. If you choose to have the COVID-19 Vaccine today, continue to follow all current guidance to protect yourself, including wearing a mask, social distancing, and washing your hands frequently.

## If you are ready to receive the COVID-19 Vaccine, please read the statements below and sign and print your name to indicate your consent.

## Section 3: Consent

☐ I have reviewed the fact sheet for the COVID-19 Vaccine (see links below) and this COVID-19 Vaccine Consent Form and/or have had any questions explained to me. I understand the FDA has authorized the emergency use of the COVID-19 Vaccine, which is not an FDA-approved vaccine.

☐ I understand that the Pfizer and Moderna COVID-19 Vaccine require two (2) doses. If this is my first dose of the 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 agree to stay in the vaccine administration area for fifteen (15) minutes (or longer if indicated by the vaccine administrator) after receiving my vaccination to ensure that no immediate adverse reactions occur, and I understand that if I experience any adverse reaction, it will be my responsibility to follow up with Student Health. I understand that the side effects reported in the clinical trials are summarized in the **FACT SHEET** for this COVID-19 vaccine. The side effects are not severe in most cases and usually resolve within 24 to 48 hours. If I have questions about side effects, I should send a message to the COVID Vaccine Nurse. I understand that certain severe allergic reactions have been reported outside of clinical trials; if I develop symptoms of an allergic reaction following vaccination (such as trouble breathing, chest pain, or a fast heartbeat, dizziness, weakness, swelling of face, throat, or tongue, or a rash all over the body), **I will call 911 or go to the nearest Hospital Emergency Department.**

☐ I understand that I may be asked additional screening questions at my appointment prior to administration of the COVID-19 Vaccine as part of this consent process to determine my eligibility to receive the COVID-19 Vaccine and/or the need for any counseling for me concerning risk based on my responses.

☐ I understand the significant known and potential risks and benefits of the COVID-19 Vaccine as explained in the FACT SHEET and that some of the potential risks and benefits may remain unknown, and **I REQUEST THE COVID-19 VACCINE BE GIVEN TO ME**.

Pfizer Fact Sheet: https://www.fda.gov/media/144414/download Moderna Fact Sheet: https://www.fda.gov/media/144638/download

**SIGNATURE OF PATIENT / LEGAL REPRESENTATIVE / PARENT OR LEGAL GUARDIAN:**
_____

**PRINT NAME:** _____ **DATE:** _____

**RELATIONSHIP TO PATIENT:** (if applicable) _____