EMORY
HEALTHCARE

COVID-19 VACCINE CONSENT FORM

Section 1: Employee/Contractor Information

NAME (Last)	(First)	**DATE OF BIRTH**	**GENDER**	**AGE**
OPERATING UNIT	**EMPLOYEE ID**	**IF CONTRACTOR, LIST EMPLOYER**		
HOME ADDRESS				
CITY / **STATE**	**ZIP**	**DAYTIME PHONE NUMBER**		
PRIMARY CARE PHYSICIAN: **Name**	**Address**	**Phone Number**		
EMERGENCY CONTACT: **Name**	**Relation**	**Phone Number**		

Section 2: Demographics

ETHNICITY ☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown
☐ Unable to report

RACE ☐ American Indian or Alaskan Native ☐ Asian ☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American
☐ White ☐ Other race ☐ Unknown
☐ Unable to report

Section 3:-ELIGIBILITY CRITERIA:

☐ I certify that, as of the date of my vaccination, I am 18 or older and I meet one or more of the Georgia Department of Public Health defined eligibility criteria to obtain the COVID-19 Vaccine. See https://dph.georgia.gov/covid-vaccine for criteria.

IS THIS YOUR ☐ FIRST OR ☐ SECOND DOSE OF THE COVID-19 VACCINE?

- **If this is your second dose, what was the date of your first dose? _____**
- **Which vaccine did you receive? ☐ Pfizer ☐ Moderna ☐ Other**

Section 4: Screening Questions

The following questions will help us determine if there is any reason you should not get the COVID-19 Vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your health care provider to explain it.

	YES	NO	Don't know
1. Are you feeling sick today? (For example, cold, fever, or acute illness)			
2. Have you received any vaccinations in the past two weeks, have you received a COVID-19 Vaccine from a different manufacturer at any time, or did you participate in a COVID-19 Vaccine trial?			
3. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19 in the last 90 days?			

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4. Have you ever had an allergic reaction to any COVID-19 Vaccine or to any of the following list of ingredients? 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. 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. In addition to a replication-incompetent recombinant adenovirus type 26 (Ad26) vector expressing the SARS-CoV-2 spike (S) protein in a stabilized conformation, the ingredients of the **J&J / Janssen COVID-19 Vaccine** are citric acid monohydrate, trisodium citrate dihydrate, ethanol, 2-hydroxypropyl-β-cyclodextrin (HBCD), polysorbate 80, and sodium chloride.			
5. Have you been diagnosed with COVID-19 infection in the last 90 days?			
6. 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)?			
7. 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)?			
8. Do you have a bleeding disorder or do you take a blood thinner?			
9. Do you have a history of a weakened immune system?			
10. Is it possible that you are or may become pregnant in the next four weeks, or are you currently breastfeeding?			

If you answered "Yes" to any of Questions 1 to 4, you should not have the COVID-19 Vaccine today:

- **If you are sick**, we recommend you contact the COVID hotline to arrange testing, and delay vaccination until your symptoms have resolved. If you are diagnosed with COVID-19 you should delay the vaccination for 90 days after diagnosis.
- **If you have received other vaccinations recently for something other than COVID-19**, it is recommended that you wait 2 weeks following that vaccine(s) prior to receiving the COVID-19 Vaccine.
- **If you have received a COVID-19 Vaccine from a manufacturer other than Pfizer or Moderna**, you should not receive a different COVID-19 Vaccine as there is no data on safety or efficacy of combining vaccines from different manufacturers. If you have received your first dose of Pfizer or Moderna, your second dose must be from the same manufacturer as the first. If you were vaccinated as part of a clinical trial, you should contact the research team with any questions or concerns about receiving a COVID-19 Vaccine.
- **If you received monoclonal antibodies or convalescent serum as treatment for COVID-19**, vaccination should be delayed for at least 90 days, as a precautionary measure until additional information becomes available, to avoid interference of the antibody treatment with vaccine-induced immune responses.
- **<u>If you have a history of an allergic reaction to any of the ingredients in the COVID-19 Vaccine, including a reaction at the time of your first dose, you should not receive the COVID-19 Vaccine at any time, based on current guidance.</u>**

If you answered "Yes" to Question 5:

- **If you have been diagnosed with COVID-19 at any time within the past 90 days**, recent COVID infection is not an absolute contraindication to vaccination, so you may choose to proceed, provided that you have met criteria to discontinue isolation.

If you answered "Yes" to Question 6:

- You should discuss your reaction history with your physician prior to making a decision to proceed with vaccination, in order to discuss the possible risks of an allergic reaction as compared to the benefits of vaccination. If you decide to go ahead, see below.

If you answered "Yes" to Questions 6, 7, or 8, 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 a history of a bleeding disorder, discuss the safety of intramuscular injection with your physician prior to proceeding. If you have either a bleeding disorder or take a blood thinner**, notify the staff at the vaccination site so that we can take any necessary precautions..

If you answered "Yes" to Question 9 or 10:

- You can choose to have the COVID-19 Vaccine today 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 statement below and sign and print your name to indicate your consent.

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Section 5: Consent

□ I have received (electronically or in hard copy) and read the **FACT SHEET**, or have had explained to me, the information in the **FACT SHEET** for the COVID-19 Vaccine and this COVID-19 Vaccine Consent Form. I understand the FDA has authorized the emergency use of the COVID-19 Vaccine, which is not an FDA-approved vaccine. I understand there is currently not enough scientific evidence for the FDA to fully approve this or any COVID-19 Vaccine. I have had the chance to ask questions that were answered to my satisfaction. I have also been informed that I can access the V-Safe reporting tool from the Centers for Disease Control at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafe.html#anchor_1607560764339.

□ I understand the COVID-19 Vaccine will be provided to me at no charge and that Emory is NOT requiring anyone to take the vaccine at this time.

□ I understand the COVID-19 Pfizer or Moderna Vaccine requires two (2) doses. If this is my first dose of the COVID-19 Pfizer or Moderna 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 understand that the J&J / Janssen COVID-19 Vaccine requires only one (1) dose.

□ I understand, in particular, that if I get the **J&J / Janssen COVID-19 Vaccine**, I should seek **immediate medical attention if I develop shortness of breath, chest pain, leg swelling, abdominal pain that doesn't go away, nervous system problems (like severe or persistent headaches or blurry vision), bruising, or tiny spots (red, brown, or purple) on my skin** within two weeks of getting this vaccination. **J&J / Janssen Fact Sheet:** https://www.fda.gov/media/146305/download

□ I understand that even though I may receive this COVID-19 Vaccine, I should continue to follow all current guidance to protect myself, including wearing a mask, social distancing, and washing my hands frequently.

□ 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 my primary care physician. 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 hours. If I have questions about side effects, I may call Employee Health at 404 686-8589, Option 1, from 7 am-11 pm Monday-Saturday and from 7 am-3 pm on Sundays 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**.

SIGNATURE OF EMPLOYEE / CONTRACTOR: _____

PRINT NAME: _____ DATE: _____

Section 6: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Dose	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Expiration Date	Name of Vaccine Administrator
COVID-19	_____ml □ 1st _____ml □ 2nd	□ IM - L Arm □ IM - R Arm					