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| --- | --- |
| C:\Moss\Administrative\983db650f7f79bc8e87d9a3ba418aefc\morrow FD patch.jpg | **COVID-19 Vaccine Registration and Consent Form**Administration Facility Name/Facility ID: Morrow Fire EMS  |

**SECTION 1: INFORMATION ABOUT YOU (PLEASE PRINT**

|  |  |
| --- | --- |
| **Name:** Last: First: | Middle Initial: **Date of Birth:** |
| **Agency:** |   |   |
| **Address:** |   | **Apt/Room #:** |
| **City:** | **State:** | **Zip:** |
| **Mobile Phone Number:** | **Email Address:** |   |
| **Sex** (Gender assigned at birth) OFemale O Male | **Race**O American Indian/Alaska NativeO AsianO Black or African American | O Native Hawaiian or otherO Pacific Islandero White | O Other Asian O UnknownO Other Nonwhite O Other Pacific Islander | **Ethnicity**O Hispanic or LatinoO Not Hispanic or LatinoO Unknown |
| **Allergies:** |   |   |

**SECTION 2: COVID-19 SCREENING QUESTIONS**

|  |  |  |
| --- | --- | --- |
| **Please check YES or No for each question.** | **Yes** | **No** |
| 1. Are you sick today?
 |   |   |
| 1. Have you had a severe allergic reaction to a previous dose of this vaccine or to any of the ingredients of this vaccine?
 |   |   |
| 1. Do you carry an Epi-pen for emergency treatment of anaphylaxis?
 |   |   |
| 1. For women, are you pregnant or is there a chance you could become pregnant?
 |   |   |
| 1. For women, are you breastfeeding?
 |   |   |
| 1. Have you had any other vaccinations in the previous 14 days?
 |   |   |
| 1. In the past two weeks, have you tested positive for COVID-19?
 |   |   |
| 1. Have you had in the last 10 days fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?
 |   |   |

**SECTION 3: IMMUNIZATION SCREENING GUIDANCE FOR COVID-19 VACCINE**

**Please check YES or No for each question.**

**Yes**

**No**

9. Do you have allergies or reactions to any medications, foods, vaccines, or latex? Please explain:

10. Are you immunocompromised or on a medicine that affects your immune system?

11. Do you have a bleeding disorder or are you on a blood thinner/blood-thinning medication?

12. Have you had any COVID 19 Antibody therapy in the last 90 days?

* I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to Morrow Fire Department EMS (MFD) or its agents to administer the COVID-19 vaccine.
* I understand that this product has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals 18 years of age and older; and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.
* I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
* I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
* I acknowledge that: (a) I understand the purposes/benefits of GRITS (Georgia Registry of Immunization Transactions and Services) and (b) MFD will include my personal immunization information in GRITS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.

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* On behalf of myself, my heirs and personal representatives, in consideration of receiving this vaccine, I hereby release MFD, its agents, designees, elected officials, representatives, and/or employees, with respect to any and all injury, disability, illness or death arising during, as a result of, or in connection with my participation in the COVID-19 vaccination program. By signing this form, I acknowledge that I have read the foregoing statements and understand and agree to the contents thereof. Nothing contained herein is intended nor shall be construed to waive employee’s statutory rights under Georgia Code, if applicable.
* I acknowledge receipt of the Notice of Privacy Rights.

**Dose 1 Consent Signature**

**Signature of Patient or Authorized Representative Date:**

**Print Name of Representative and Relationship to Person Receiving Vaccine:**

**Dose 2 Consent Signature**

**Signature of Patient or Authorized Representative Date:**

**Print Name of Representative and Relationship to Person Receiving Vaccine:**

**This Section to be Completed by Staff at Time of Vaccination**

|  |  |  |
| --- | --- | --- |
|  | **Dose # 1** | **Dose # 2** |
| **Screener Name** |  |  |
| **Screener Signature** |  |  |
| **Date of Administration** |  |  |
| **Vaccine Manufacturer (MVX)** | **Moderna** | **Moderna** |
| **Lot Number** |  |  |
| **NDC Number** |  |  |
| **Expiration Date** |  |  |
| **Route** | **Intramuscular** | **Intramuscular** |
| **Site (Left/Right Deltoid)** |  |  |
| **Date of EUA Fact Sheet** | **12/01/2020** | **12/01/2020** |
| **Administered at Location - Facility Name/ID** | **Morrow Fire Department** |  |
| **Administered at location: Type** | **Fire Rescue Headquarters** |  |
| **Administration Address** | **1500 Morrow Road Morrow, GA 30260** |  |
| **CVX (product)** |  |  |
| **CPT Billing Code** |  |  |
| **Sending organization** |  |  |
| **Vaccinator Name** |  |  |
| **Vaccinator Signature** |  |  |
| **Observation Time In** |  |  |
| **Observation Time Out** |  |  |
| **Data Entry Name** |  |  |
| **Data Entry Signature** |  |  |
| **Data Entry Date** |  |  |
| **Date/Time for Dose 2** |  |  |

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