



Georgia Department of Public Health

District 4 Public Health

COVID-19 VACCINE INFORMATION AND CONSENT FORM

Name: First Middle Last
Address: Street City State Zip
Telephone: ( ) --
SSN

Date of Birth: -- --
Age:
Gender: Male Female
Primary Language: English Other
Ethnicity: (check only 1) Not Hispanic Hispanic Unknown

Race: (check only 1) Asian/Polynesian Black Multiracial White Native Am/Alaskan Unknown

Table with 4 columns: Question, Yes, No, Do Not Know. Contains 11 health questions regarding COVID-19 symptoms, allergies, and medical history.

I have been given a copy and have read the Emergency Use Authorization (EUA) or the Vaccine Information Statement (VIS) for the COVID-19 Vaccine. I have had the chance to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of the vaccine requested and ask that the vaccine indicated be given to me or the person named for whom I am authorized to make this request.
My signature acknowledges that I was advised to remain on site for 15 minutes after receiving the vaccine. Those with previous anaphylactic reactions should stay for 30 minutes.
Date Print Name Patient/Guardian Signature

Table with 8 columns: OFFICE USE ONLY, Record of Immunization, OFFICE USE ONLY. Sub-columns: Manufacturer, Lot #, Expiration, Dosage, Route, Site, EUA/VIS, Provider Signature/Date.