GWINNETT CLINIC

Thank you for choosing Gwinnett Clinic!

In order make your appointment safe and efficient, please bring physical copies of the following documents with you:

- ❒ Completed consent form
- ❒ Copy of government issued photo ID (preferably driver's license)
- ❒ Copy of the **front** of your insurance card
- ❒ Copy of the **back** of your insurance card
- ❒ Wear a short sleeve shirt
- ❒ Plan ahead for your second dose in 3-4 weeks depending on which vaccine you receive

FDA EUA statements and other important clinical / safety sheets are available for your review on our website at www.GwinnettClinic.com/vaccine or you can scan the QR code below!

We look forward to seeing you!

Updated March 17, 2021

GC Location: _____

Gwinnett Clinic 2021 COVID-19 Vaccine Consent

GWINNETT CLINIC

Please print information for person receiving vaccine

Full Name	Date of Birth (mm/dd/yyyy)	Age: Gender ☐ Male ☐ Female
Telephone Number	Address (SPECIFY COUNTY)	Are you, or could you be, pregnant or breastfeeding? ☐ Yes ☐ No

COVID-19 Vaccine Administration & Release and Signed Consent

The Food and Drug Administration (FDA) has recently issued an Emergency Use Authorization for a COVID-19 vaccine. Gwinnett Clinic is making this vaccine available to me and I have requested to receive the vaccine. I have received the FDA Fact Sheet on this vaccine, which informs me of the significant known and potential risks and benefits of emergency use of this vaccine as well as potential alternatives, risks, and benefits. I understand that I have the option to accept or decline this vaccine. Declining this vaccine will not affect my employment status or insurance benefits. I hereby consent to and authorize Gwinnett Clinic, through its designated agents or representatives, to administer the vaccine as indicated below. I hereby release Gwinnett Clinic and its agents and employees from any and all liabilities in connection with this vaccine and the administration to me. I acknowledge that no guarantee or assurance has been made to me concerning the results that may be obtained from the administration of this vaccine. GWINNETT CLINIC, BY ADMINISTERING THE VACCINE TO ME PROVIDES NO WARRANTY WITH RESPECT TO THE VACCINE AND GWINNETT CLINIC SPECIFICALLY DISCLAIMS ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE CONCERNING THE VACCINE.

☐ **I CONSENT TO THE ADMINISTRATION OF THE COVID-19 VACCINE BY GWINNETT CLINIC.**

	YES	NO
1. Are you feeling sick today?		
2. Have you received a dose of COVID-19 vaccine? • If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product_____		
3. Have you ever had an allergic reaction after a dose of any vaccine or injectable medication? **If YES, STOP AND SPEAK WITH YOUR PROVIDER.**		
4. Do you have a severe (life-threatening) allergy to ANY component of this vaccine as detailed in the Emergency Use Authorization (EUA)?		
5. Have you had any vaccine in the past 30 days and will you receive another vaccine in the next 30 days?		
6. Are you currently under isolation (infected with COVID-19) or exposed to someone with COVID-19?		
7. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?		
8. Do you have a weakened immune system caused by HIV infection or cancer or do you take immunosuppressive drugs or therapies?		
9. Do you have a bleeding disorder or are you taking a blood thinner?		
10. Do you have derma fillers?		

I have:

* received, read, and understand the Vaccine Information Statement and/or the Emergency Use Authorization for the vaccine I am receiving;
* received the Gwinnett Clinic HIPAA Notice of Privacy Policies;
* had the opportunity to discuss any medical concerns with my healthcare provider or a healthcare provider at the vaccination clinic.

PLEASE ASK ALL YOUR QUESTIONS BEFORE RECEIVING THE COVID-19 VACCINE.

I understand the risks of this vaccine and ask it be given to me or to the person for whom I am authorized.

Signature _____ **Date (mm/dd/yyyy)** _____

Printed Name _____ **Relationship to Patient (if applicable)** _____

Please return this complete consent form along with copy of a government issued ID (preferably your driver's license), a copy of your insurance card, a printout of your insurance verification, proof of working as a medical personnel, and registration paperwork.

OFFICIAL USE ONLY

☐ Dose 1 ☐ Dose 2	Type of Vaccination: mRNA COVID-19 Vaccine	Route of Administration: Intramuscular
Location (circle one): Left / Right Deltoid	Manufacturer (circle one): Pfizer / Moderna	Exp Date: (mm/dd/yyyy):
Lot Number:	Date Administered (mm/dd/yyyy):	Time Administered:
Intake Staff (Print Full Name):	Vaccinator (Print Full Name):	

Check when complete: ☐ Checked in ☐ Entered into GRITS ☐ Vaccine log completed ☐ Follow-up appointment