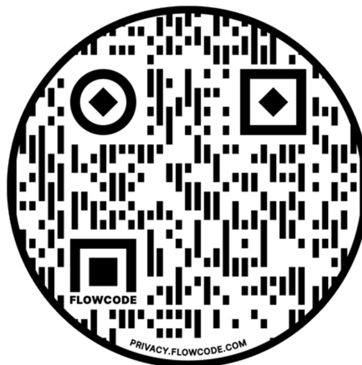
Thank you for choosing Gwinnett Clinic!

Vaccine Location:
10600 Medlock Bridge Rd.
Duluth, GA 30097

In order to help make your appointment as smooth as possible, 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
- ❒ Proof of working as medical personnel, can include:
    - Medical license
    - Employee badge
    - Letter from employer on official letterhead
    - Pay stub
- ❒ Printout of your insurance verification (if possible, to expedite your visit)
- ❒ Completed new patient paperwork (if follow-up with a Gwinnett Clinic provider is desired)

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!

GC Location: _______________

Gwinnett Clinic 2020- 2021 COVID-19 Vaccine Consent

Please print information for person receiving vaccine

Full Name	Date of Birth (mm/dd/yyyy)	Age	Telephone Number

Address	City	State	Zip

Marital Status (Check One)	Race - You May Check More Than One Category	Ethnicity	Gender	Are you, or could you be, Pregnant?
☐Married ☐Widowed	☐African American ☐Asian ☐White	☐Hispanic	☐Male	
☐Single ☐Divorced	☐American Indian/Alaskan ☐ Pacific Islander ☐Other	☐Non-Hispanic	☐Female	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, their 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 NORTHSIDE HOSPITAL 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.

INITIAL ALL THAT APPLY:

I (person receiving vaccine):

_______ have NEVER had a life-threatening allergic reaction after a dose of any vaccine or injectable medication;

_______ have NOT had any vaccine within the past 14 days and will NOT receive another vaccine within the next 14 days;

_______ am NOT currently under isolation (infected with COVID-19) nor under quarantine (exposed to someone with COVID-19);

_______ am NOT currently moderately or severely ill;

_______ have NOT received monoclonal antibody therapy or convalescent plasma for COVID-19 treatment in the past 90 days;

_______ do NOT have a severe (life-threatening) allergy to any component of this vaccine as detailed in the Emergency Use Authorization.

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 that this vaccine be given to me or to the person named above for whom I am authorized to make this request.

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

Type of vaccination: mRNA **COVID-19 Vaccine** | Route of administration: **Intramuscular** Location: **Left or Right Deltoid**

Date of vaccination:________/________/__________(mm/dd/yyyy) **Time**:____________am/pm

Product: **Covid-19 Vaccine**

Manufacturer (please circle): Pfizer/Moderna Lot number: Exp Date:_____ /_____ /_________(mm/dd/yyyy)

Vaccine Dose: ☐ Dose 1 ☐ Dose 2

Intake Staff (Print Full Name): | Vaccinator (Print Full Name):