COVID-19 VACCINE PATIENT ACKNOWLEDGMENT

LAST NAME:_____ **FULL LEGAL FIRST NAME:**_____ **Middle Initial:** ___

Maiden Name:_____ **DOB (MM/DD/YYYY):**_____ **PHONE:**_____

EMAIL:_____ **ADDRESS**:_____ **CITY**: _____

STATE:_____ **ZIP**: _____

RACE: ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race ☐ Prefer Not to Answer **SEX**: _____

ARE YOU HISPANIC OR LATINO?: ☐ Yes ☐ No

ACKNOWLEDGEMENTS:

- I will/have reviewed my answers to the questions on the back of this page with the vaccinator. If I experience any adverse reactions after leaving, I will notify my primary care provider. I have viewed the Emergency Use Authorization (EUA) Fact Sheet or Vaccine Information Statement (VIS) available to me today. I understand the benefits and risks of the vaccine.
- I had the chance to ask questions that were answered to my satisfaction. I now know about the vaccine, alternatives, benefits, and risks, to the extent they are known and unknown at this time.
- I know that I must stay in the vaccine area or an area told to me by my health care provider after I receive my immunization so I am near my health care provider if I have any adverse reactions. If I have a history of certain allergic reaction(s), I must stay for 30 minutes. If I do not have a history of such an allergic reaction(s), I must stay for 15 minutes.
- I have viewed the V-SAFE program information sheet available to me today. The program does health checks on the people who get the COVID-19 vaccine. I know I should report vaccine side effects to FDA/CDC Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967or https://vaers.hhs.gov/reportevent.html.
- I know I must get two doses of the Moderna or Pfizer COVID-19 vaccines and must receive the same vaccine each time. I know that with all vaccines there is no promise I will become immune (not get the virus) or that I will not have side effects. I know I may choose to not get the second dose of the vaccine. But if I do not get the second dose, the chance that I will become immune may go down.
- By signing this form, I give permission for a vaccine to be administered to the person listed on this acknowledgment form.

Disclosure of Records: I understand the organization providing my vaccine may be required to or may voluntarily disclose my vaccine-related health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also understand the organization providing my vaccine will use and disclose my health information as described in its Notice of Privacy Practices which I may receive upon request or find on its website.

Patient Signature:_____ Date: _____

If Patient is under age of 18, Parent, Guardian or Authorized Representative signature is required.

Guardian Signature:_____ Relation to Patient:_____ Date: _____

If you are signing on behalf of the patient, you are stating that you are authorized to make the required decisions on behalf of the patient.

FOR ADMINISTRATIVE USE

<table>
<tr><td rowspan="2">VACCINE INFO:
0001A
91300
Diagnosis: Z23

Lot #:
Expires:</td><td colspan="3">LOCATION:
RT DELT LT DELT</td></tr>
<tr><td>INITIALS:_____
DATE: _____</td><td>DOCUMENTER:</td><td>Added to IIS?
Y N</td></tr>
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Screening Checklist for Contraindications to COVID-19 Vaccination			
For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child the COVID-19 Vaccine. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your health care provider to explain it.	**Yes**	**No**	**Unsure**
Is the person to be vaccinated sick today?	☐	☐	☐
Are you under age 12?	☐	☐	
In the past 10 days, have you had a COVID-19 test or been told by a Healthcare Provider or health department to isolate or quarantine at home due to COVID-19 Infection or exposure?	☐	☐	☐
Have you been treated with antibody therapy for COVID-19 in the past 90 days? *(This excludes a dose of COVID-19 vaccine)* If yes, when did you receive the last dose?	☐	☐	☐
Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing after receiving any vaccine or shot or due to any other cause? If so, what was the cause?	☐	☐	☐
Are you pregnant or considering becoming pregnant?	☐	☐	☐
Have you had any vaccines in the past 14 days including a flu shot? If so, when and what kind of vaccine?	☐	☐	☐
Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system? Is so, please note:	☐	☐	☐
Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	☐	☐	☐
If this is your second or third dose of a COVID-19 vaccine, which vaccine have you received previously? What was the date of your last COVID-19 vaccination?	(Circle one) Moderna / Pfizer / J & J		