



COVID-19 Vaccine Administration Record & Informed Consent

Patient's Name _____ Birth Date: ____/____/____ Age: _____
Last First Middle Month/Day/Year

Street Address: _____
APT # CITY STATE ZIP CODE

Phone Number : _____ Gender: Female Male Transgender: Female to Male Male to Female

Language most comfortable speaking: _____ Do you need an interpreter? Yes No

Hearing impaired or need sign language interpreter services? Yes No

Ethnicity:	Non-Hispanic	Hispanic/Latino	Prefer not to answer
Check one			

Race:	<input type="checkbox"/> African American/Black	<input type="checkbox"/> Caucasian/White (including Hispanic)	<input type="checkbox"/> Asian
Check all that apply	<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> Native American Indian/Alaska Native	
	<input type="checkbox"/> Other _____	<input type="checkbox"/> Prefer not to answer	

Patient Emergency Contact: (For emergency only such as passing out or needing to be taken to a hospital)

Name _____ Relationship: _____ Phone Number: _____

Please answer the questions below to help us determine if there is any reason you should not get the COVID-19 vaccine today.
If you need help, please ask a staff person.

IS THE PERSON RECEIVING THE COVID 19 VACCINE:	Yes	No	Don't Know
1. Feeling sick today?			
2. Ever received COVID Vaccine before? If yes, what product? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Other			
3. Ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen® or that you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or injectable medication?			
4. Received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Received <u>any vaccine</u> within the past 14 days?			
6. Ever had a positive test for COVID-19 or had a doctor ever told you that you had COVID-19?			
7. Have a weakened immune system caused by something such as HIV infection or cancer or take immunosuppressive drugs or therapies?			
8. Have a bleeding disorder or taking a blood thinner?			
9. FOR FEMALES 9 years old or older: Are you pregnant or breastfeeding?			

Informed Consent: I answered all the questions correctly to the best of my knowledge. I have read or have had explained to me the information contained in the EUA Fact Sheet or VIS about COVID 19 disease/vaccine. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine and request this vaccine be given to me or to the person named above for whom I am authorized to make this request. I answered all the questions correctly to the best of my knowledge. I ACKNOWLEDGE THAT A COPY OF THE "NOTICE OF PRIVACY PRACTICE" HAS BEEN MADE AVAILABLE TO ME.

SIGN HERE: _____ **Date:** _____
 Self Parent/Guardian

AREA BELOW FOR SNHD STAFF ONLY							
Vaccine	Date Given	Dose #	Mfg & Lot #	Site	Route	EUA/VIS Date	Administered & Reviewed by:
COVID-19				LA LT RA RT	IM	Moderna 12/20 Janssen (J&J) 2/21 Pfizer 12/20	N P

NV Web IZ Record # _____ **EUA Confirmed by (Initials)** _____ Data Entry by (Initials): _____

Clinic Location: Main ELV Hend Mesquite Other _____ **Roseman**

01/02/21 JR