

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Gender: Male Female

Address: _____

Mailing Address: _____

Phone Number: _____ Mother's Maiden Name (optional): _____

Race: African American American Indian/Alaskan Native Asian
(Check all that apply) Native Hawaiian/Pacific Islander White Decline to Answer

Ethnicity: Hispanic? Yes No Decline Primary Language: _____

Social Security Number (optional): _____ — — _____ Medicaid ID Number (optional): _____

☐ I have received this clinic's HIPAA Notice of Privacy Practices

Patient Screening Questions

	Select one:		
Do you have a fever or feel sick today?	Yes	No	
Have you ever received a dose of COVID-19 vaccine?	Yes	No	Don't know
If yes, which vaccine product? Pfizer Moderna Other			
Have you 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 for which you had to go to the hospital?	Yes	No	Don't know
Was the severe allergic reaction after receiving a COVID-19 vaccine?	Yes	No	Don't know
Was the severe allergic reaction after receiving another vaccine or another injectable medication?	Yes	No	Don't know
Have you received another vaccine in the last 14 days?	Yes	No	
Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	Yes	No	Don't know
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	Yes	No	Don't know
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	Yes	No	
Do you have a bleeding disorder or are you taking a blood thinner?	Yes	No	
Has the patient ever fainted after injections?	Yes	No	
Are you pregnant or breastfeeding?	Yes	No	

Patient Name: _____

I have received the Vaccine Information Statement(s) for the vaccines to be given and I have had all of my questions answered. I request that the vaccine be given to me or to the person named above, for whom I am responsible. I allow the release of any information needed to process insurance claims and request payments of medical benefits.

Print name: _____

Signature: _____

Relationship to patient: _____

Date: _____

For office use only

Patient risk group

1.A

1. Hospitals, urgent care, skilled nursing and memory care residents and staff, tribal health, EMS
2. LTCF, congregate care sites, hospice programs, mobile crisis care, corrections staff, secure transport
3. Outpatient settings serving high-risk, in-home care, day treatment, non-emergency medical transport
4. Outpatient health care workers, public health sites, early learning sites, death care workers

1.B

1. Essential worker
2. Person over 75 years of age

1.C

1. Person over 65 years of age
2. Person with underlying health condition

Dose #	Vaccine	Brand Name	Lot Number	Exp.	Manuf.	Dose (ML)	Site/Rte	Elig.	EUA Pub Date	EUA VIS Given
	COVID-19				Pfizer-BioNTech	0.3		S	12/2020	
					Moderna	0.5		S	12/2020	
	Other									

Vaccine Administrator Signature: _____ Title: _____ Date: _____