**Information about person to receive vaccine (please print)**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth date**: \_\_\_/\_\_\_/\_\_\_\_\_ **Age**: \_\_\_\_\_\_\_ **Sex**: ☐ Male ☐ Female

**Race**: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other **Ethnicity**: ☐Hispanic ☐Non-Hispanic

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_ **Zip**: \_\_\_\_\_\_\_

**Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Do you have insurance?** ☐ No ☐ Yes

**The following questions will help determine if there is any reason you should not receive a COVID immunization injection.**

*Answering “yes” to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.*

|  |
| --- |
| Has the person to be vaccinated ever received a COVID-19 vaccine? ☐ No ☐Yes  If yes, date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type/Brand of COVID vaccine:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does the person to be vaccinated have an allergy to any medications, food, vaccine, or latex? ☐ No ☐Yes |
| List all allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy? ☐ No ☐Yes |
| Is the person to be vaccinated sick today? ☐ No ☐Yes |
| Is the person to be vaccinated at least 18 years old? ☐ No ☐Yes  If no, is the person to be vaccinated at least 16 years old? ☐ No ☐Yes |
| Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner? ☐ No ☐Yes  Has the person to be vaccinated received any other vaccines in the past 14 days? ☐ No ☐Yes  Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19? ☐ No ☐ Yes |

I have read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian).

**I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.**   
Print Parent/Guardian name, if different from client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**FOR CLINIC USE ONLY**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Clinic site****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* ***EUA Fact Sheet Provided****: Yes No*

***Date vaccine administered****: \_\_\_\_/\_\_\_\_/\_\_\_\_\_* ***Date booster required****: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_*

***Vaccine manufacturer****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* ***Lot number****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Site of IM injection****: RDT or LDT or \_\_\_\_\_\_\_\_\_\_\_* ***Dose****: 0.3ml 0.5ml*

***Signature and title of vaccine administrator****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Nurse’s Comments****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**INSURANCE INFORMATION**

(Please give your insurance card to the receptionist)

Primary Insurance:

Subscriber’s Name: Date of birth:

Group No:

Policy No:

Client’s relationship to subscriber:

Secondary Insurance:

Subscriber’s Name: Date of birth:

Group No:

Policy No:

Client’s relationship to subscriber:

The above information is true to the best of my knowledge. If qualified, I authorize billing to my insurance company and release of information required to process my claims.

I authorize my insurance benefits be paid directly to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Client Signature Date