**COVID-19 Vaccination Documentation**

There is no co-pay for individuals with insurance and no charge for individuals who are not insured

 **Patient** :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**:\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_

 Last name First name

**Gender:** Male Female **Race:** WhiteBlack/African AmericanHispanic/ LatinoAsian

Pregnant? American Indian Hawaiian or Other Pacific IslanderOtherUnknown **Ethnicity:** Hispanic or LatinoNot Hispanic or LatinoUnknown

**Do you live in a Resident or Congregate Setting?** Yes No

**I verify I am in priority group (check appropriate box)** 1a 1b (See separate list for priority group populations)

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Street address City State ZIP CODE

**Home Phone**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you feeling well today?** Yes No

* Vaccination not recommended during moderate to severe illness

**Have you had a SEVERE allergic reaction (e.g. anaphylaxis) to any ingredient in this vaccine?** Yes No

* Including polyethylene glycol or polysorbate. For a complete list of components see the Fact

Sheet for Recipients and Caregivers provided.

**Have you had a SEVERE allergic reaction (e.g. anaphylaxis) to any other vaccine or injectable therapy?** Yes No

**Did you have a SEVERE allergic reaction to a previous dose of COVID-19 vaccine?**  Yes No N/A - First dose

**Have you received any vaccines in the last 14 days?** Yes No

**Consent for Vaccination**

I have read or have had explained to me the vaccine information sheet about the vaccine that will be administered. I have had the opportunity to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the recommended vaccine be given to me or the person named above for whom I am authorized to make this request.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Representative Signature/Relationship (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Verbal Consent obtained by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of person obtaining verbal consent

**Immunization Information:**

 Fact Sheet for Recipients and Caregivers Given to Patient

Moderna COVID-19 Vaccine

Pfizer COVID-19 Vaccine

MFG Lot #: Exp. Date: Site: Right Arm Date: \_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_

 Left Arm First Dose Second Dose

Nurse Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_