COVID-19 Vaccine Administration Record & Informed Consent

Patient's Name: _____ **Birth Date:** __/__/__ **Age:** _____
First Middle Last MM DD YY

Street Address: _____ **Phone Number:** _____

City _____ State ____ Zip Code _____ **Email:** _____

Gender:	☐ Male ☐ Female ☐ Other
Dose: (check one)	☐ 1st ☐ 2nd
Race: (check all that apply)	☐ Asian ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Black ☐ American Indian or Alaska Native ☐ Other or Multiple Races ☐ Prefer Not to Answer
Ethnicity: (check one)	☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Unknown or Prefer Not to Answer
Disability: (Please answer for any disability that you identify as having)	☐ Yes ☐ No ☐ Prefer not to Answer

Is/Has the person receiving the COVID 19 vaccine:	Yes	No	Don't Know
1. Feeling sick today? If yes, what are their symptoms?			
2. Ever received COVID Vaccine before? If yes, what product? ☐ Pfizer ☐ Moderna ☐ Other			
3. Have any allergies, such as medications, foods, a vaccine component, or latex?If so, list what allergies:			
4. 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?			
5. Ever had Guillian-Barre Syndrome in the past?			
6. Received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
7. Received <u>any vaccine</u> within the past 14 days?			
8. Ever had a positive test for COVID-19 or had a doctor ever told you that you had COVID-19?			
9. Have a weakened immune system caused by something such as HIV infection or cancer or take immunosuppressive drugs or therapies?			
10. Have a bleeding disorder or taking a blood thinner?			
11. Are you pregnant or breastfeeding?			

Read and Initial. Then SIGN and date below.	Initial
I have been provided a link to the information provided in the Emergency Use Authorization Fact Sheet and I have had the opportunity to ask questions for the immunization(s) to be administered to me or the person named above, for whom I am authorized to make this request. ***(To be initialed with the vaccine provider)***	
I agree to allow my immunization information, or the person named above, for whom I am authorized to make this request, to be stored and accessed by authorized users in "Nevada's WebIZ" computer system unless I indicate otherwise.	
I also agree to have my blood tested or the person named above, for whom I am authorized to make this request, for bloodborne bacteria and viruses that may result in disease in the event a person is exposed to my blood or body fluids, or the person named above.	
By signing this document, I declare that the above information is true and accurate to the best of my knowledge.	
SIGNATURE: _____ Date: __/__/____ Parent/Guardian signature is required if under 18 years of age.	

CLINIC USE ONLY-Do not write below this line

Administered by: _____ Date: __/__/____ ☐ Route ☐ RD ☐ Other

Credential: _____ ☐ IM ☐ LD

Provider PIN: Dose # Series Complete: Y/N