

# 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:** \_\_\_\_\_

<b>Gender:</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other
<b>Dose:</b> (check one)	<input type="checkbox"/> 1st	<input type="checkbox"/> 2nd	
<b>Race:</b> (check all that apply)	<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian/Pacific Islander
	<input type="checkbox"/> Black	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Other or Multiple Races
			<input type="checkbox"/> Unknown
			<input type="checkbox"/> Prefer Not to Answer
<b>Ethnicity:</b> (check one)	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Non-Hispanic or Non-Latino	<input type="checkbox"/> Unknown or Prefer Not to Answer
<b>Disability:</b> (Please answer for any disability that you identify as having)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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? <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> 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. <b>(To be initialed with the vaccine provider)</b>	
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: ____/____/____	<input type="checkbox"/> Route	<input type="checkbox"/> RD <input type="checkbox"/> Other
Credential: _____		<input type="checkbox"/> IM	<input type="checkbox"/> LD
Provider PIN: _____	Dose # _____	Series Complete: Y/N	