COVID-19 Vaccine

Dose #2

Date:_____

Allergies_____

First name_____ **Last name**_____

Date of Birth: _____

Street Address _____

City _____ **County** _____ **Zip Code** _____

Home phone #: _____**Cell phone #:** _____

Email:_____

❑ I do not have an email/I do not wish to disclose this information

PRE-VACCINATION CHECKLIST	Yes or No
What COVID-19 vaccine product were you given for your fist dose of vaccine? MODERNA _____ PFIZER _____ Don't Know _____	
Are you feeling sick today?	
SINCE RECEIVING YOUR FIRST DOSE OF COVID-19 VACCINE, HAVE YOU HAD AN ALLERGIC REACTION TO • a component of a COVID-19 vaccine, including polyethylene glycol (PEG) which is found in some medications, such as laxatives and preparations for colonoscopy procedures • Polysorbate • Your 1st dose of COVID-19 vaccine	
Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?	
Do you have a history of allergies? If yes, please list:	
Do you have a bleeding disorder or are you taking a blood thinner? Have you talked with your doctor about getting this vaccine ?	
Are you currently pregnant?	
Have you had any type of vaccination in the past 14 days?	

CONSENT

I certify that I am: (a) at least 18 years of age (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an "applicable Provider"), to share my personal, demographic, and health condition information in order to provide me with vaccination services for the COVID-19 vaccine. I understand that the health data shared within this questionnaire will be used to determine my eligibility for receiving the COVID-19 vaccination and further determining timing of when the vaccine will be made available to me.

Signature: _____

Disclosure statement: Life threatening allergic reactions to vaccines are very rare. Signs of an allergic reaction include: shortness of breath, hoarseness or wheezing, hives, paleness, weakness, elevated heart rate, or severe dizziness. These symptoms may occur within a few minutes or up to 48 hours after the vaccination. If the recipient is experiencing any of these symptoms, the recipient has been instructed to contact a healthcare provider immediately.

_____**VERBAL CONSENT**: The recipient or legal guardian has been provided the benefits and potential adverse reactions, and provides consent to receive the vaccine.

FOR OFFICE USE ONLY:

Administration Date: _____ Administration Time: _____AM____ PM____

Vaccine Dose ____ 2nd dose

Vaccine Administration Site:

____ Left Deltoid

_____Right Deltoid

Vaccine Route of Administration:

——-Intramuscular

Administered By:

_____
Signature and credentials

Print name _____

ALLERGIES– 30 minutes