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

COVID-19 Vaccination Documentation

Patient :____ **Date of Birth**:____________ Age:________
Last name First name

Gender: ☐ Male ☐ Female ☐ Pregnant?
Race: ☐ White ☐ Black/African American ☐ Hispanic/ Latino ☐ Asian ☐ American Indian ☐ Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

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 ☐ Left Arm Date: ___________ Time: ___________
☐ First Dose ☐ Second Dose

Nurse Signature:____ Date: ____________________________