

COVID-19 Vaccine Patient Acknowledgment

Patient Name (Last, First, Middle Initial): _____ DOB: ____/____/____

Phone: _____ Mobile Phone: _____ Email: _____
 (This information will be used to contact you for your second dose reminder.)

Address: _____ City, State, Zip Code: _____

Information collected in this section helps ensure we deliver equitable and patient-centered care:

Sex listed at birth (check one):

Male: <input type="checkbox"/>	Female: <input type="checkbox"/>
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Gender identity (check one):

Male: <input type="checkbox"/>	Female: <input type="checkbox"/>	Non-Binary <input type="checkbox"/>	Unspecified/Indeterminate: <input type="checkbox"/>
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Ethnicity (Check one):

Hispanic or Latino (Including Spanish, Mexican, Puerto Rican, Cuban, etc. <input type="checkbox"/>	Not-Hispanic A person NOT of Spanish culture or origin <input type="checkbox"/>
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Race: (Check all that apply):

Black or African American <input type="checkbox"/>	Asian <input type="checkbox"/>	Hawaiian or Pacific Islander <input type="checkbox"/>
White <input type="checkbox"/>	American Indian or Alaska Native <input type="checkbox"/>	

Vaccine Dose (check one): 1st 2nd **If this is your second dose, what vaccine was your first?** Pfizer Moderna Don't know
Booster Dose Check which apply: Immunocompromised (Pfizer/Moderna) Pfizer Booster: 18-64 Occupational setting
 65 yr. old + LTC Resident Other (Booster Dose should be 6 months after 2nd dose)

Exclusion Questions: Answering yes to either of these questions may exclude you from receiving the vaccine.

Do you have a known history of a severe allergic reaction (e.g. anaphylaxis) to this vaccine or any components of the vaccine including lipids, tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose. (Full list is available in the <i>Fact Sheet for Vaccine Recipients and Caregivers</i> or from your health care provider.)	Yes	No
Are you under the age of 18 years (Moderna) under 12 years (Pfizer)?	Yes	No

Screening Questions: *Immunizer: If patient answers "yes" to any of the below, provide patient counseling or instruct them to consult with their caregiver prior to receiving the vaccine.*

In the past two weeks have you tested positive for COVID-19?	Yes	No
In the past two weeks have you had exposure to a person who tested positive for COVID-19 at a distance of six feet or less for a period of 15 or more minutes without wearing appropriate personal protective equipment?	Yes	No
Have you had a new onset of fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea?	Yes	No
In the past 90 days have you received passive antibody therapy as part of COVID-19 treatment?	Yes	No
Are you pregnant or breastfeeding or do you plan to become pregnant?	Yes	No
Are you immune compromised or on a medicine that affects your immune system?	Yes	No
Do you have a bleeding disorder or are you on a blood thinner?	Yes	No
Do you have a history of severe allergic reaction (e.g. anaphylaxis) to another vaccine or injectable medication? If yes, what vaccine or injectable medication: _____	Yes	No

Disclosure of Records: I understand the organization providing my vaccine may be required to or may voluntarily disclose my vaccine-related health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries or other public health authorities, for purposes of treatment, payment or health care operations. I also understand the organization providing my vaccine will use and disclose my health information as described in its Notice of Privacy Practices which I may receive upon request. If I am an employee of Pullman Regional Hospital I understand that it will keep records of this vaccination for me in my employee occupational health records, to the extent required or permitted by law.

Patient (or Parent/Guardian/Authorized Representative) Signature: _____ Date: _____

Name of Parent, Guardian or Authorized Representative: _____ Date: _____

If you are signing on behalf of the patient, you are stating that you are authorized to make the required decisions on behalf of the patient.
