COVID-19 Vaccine Patient Acknowledgment (DOSE 1ST___ 2ND___ 3RD___ 4th___)

Sid's PHARMACY

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: □	Female: □

Gender identity (check one):

Male: □	Female: □	Non-Binary □	Unspecified/Indeterminate: □

Ethnicity (Check one):

Hispanic or Latino (Including Spanish, Mexican, Puerto Rican, Cuban, etc. □	Not-Hispanic A person not of Spanish culture or origin □

Race: (Check all that apply):

Black or African American □ White □	Asian □ American Indian or Alaska Native □	Hawaiian or Pacific Islander □

Vaccine Dose (check one): 1st □ 2nd □ 3rd□ 4thd□ which Vaccine Series did you receive? □ Pfizer □ Moderna □ Don't know
4th Dose Booster: □ Immunocompromised (Pfizer/Moderna) Attestation Form Filled Out □

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 *Fact Sheet for Vaccine Recipients and Caregivers* or from your health care provider.)	Yes ☐	No ☐
Are you under the age of **12 years**?	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.*

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

Printed Name of Parent, Guardian or Auth. Rep.: _____ Relationship: _____

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.