Mountainlands Family Health Center

# COVID-19 Immunization Form

**Patient Name**:_____**Date of Birth:**_____**Age:** _____

**Address:**_____**City:**_____**State:**_____**ZIP:** _____

**Phone#:** (_____)_____-_____ **Email:**_____**Gender:** Male Female

**Race (Circle):** African American Alaskan Native Asian/Pacific Islander Native American White Other

**Ethnicity:** Hispanic? Yes No

| ***Please answer these questions concerning the individual receiving immunizations today*** | ***Yes*** | ***No*** |
|---|---|---|
| Are you moderately to severely sick and/or have you had a fever within the last 24 hours? | | |
| Do you have allergies to medications, food, latex, or any vaccine? | | |
| Have you had a serious allergic reaction in the past (anaphylaxis)? | | |
| Have you ever had an allergic reaction (of any severity) to mRNA COVID-19 vaccine, or any of its components including polyethylene glycol (PEG) or polysorbate? | | |
| Do you carry an Epi-pen? | | |
| Have you been diagnosed/treated for COVID-19 in the last 90 days? | | |
| Are you a child or adolescent taking aspirin therapy? | | |
| If you are female, are you pregnant or breastfeeding? | | |
| **HAVE YOU RECEIVED A PREVIOUS DOSE OF COVID-19 VACCINE? IF YES, WHAT DATE?** | | |
| Are you under the age of 16 to 18? | | |

**Please Initial and Sign the Following:**

I have been given a copy and have read or had explained to me the information contained in the **Vaccine Information Statement(s**) about the disease(s) and vaccine(s). Any questions I had were answered to my satisfaction. I understand the benefits and risks of the vaccine(s). I hereby request that the vaccine(s) indicated be given to me or the person for whom I am authorized to make this request.

I certify that I have received a copy or been given the opportunity to read the **Notice of Privacy Practices.** I understand that immunization records may be shared with schools, day care centers, health care providers, and other reasonably pertinent organizations/authorities to verify immunization status. This information may be shared with State of Federal Public Health officials or studies when medically necessary or for record- keeping purposes.

_____ I understand that I should not have any screening mammograms for up to 4 to 6 weeks after receiving the vaccine.

**Authorization Signature:**_____**Date:** _____

*****For internal use only***** **VIS:** _____ **USIIS:**_____ **MA Initials:** _____

| VACCINE | SITE | LOT # | DATE OF ADMINISTRATION |
|---|---|---|---|
| **Moderna Dose #1** | | | |
| **Moderna Dose #2** | | | |
| **Johnson & Johnson** | | | |
| **Pfizer Dose #1** | | | |
| **Pfizer Dose #2** | | | |
| **Other:** | | | |

**Following your vaccination, you should stay to be observed for (circle) 15 / 30 minutes**.

CV 03/21

Form Reviewed by: _____
Date:_____