COMMUNITY HEALTH ALLIANCE

Vaccine Informed Consent (COVID)

Patient Information

First Name: _____ Last Name: _____ Date of Birth: _____ Age: ____

Address: _____ Phone: _____

_____

Insurance Information

Insurance Name: _____ BIN Number: _____

ID Number: _____ Group Number: _____

Medicare Beneficiaries:

SSN: _____

COMPLETE FOR MODERNA OR PFIZER SERIES ONLY

Are you here to receive: ☐ **DOSE 1** ☐ **DOSE 2** ☐ **DOSE 3**

Please circle: **Moderna or Pfizer**

*Date of DOSE 1: ___/___/___

*Date of DOSE 2: ___/___/___

Screening Questionnaire

	Yes	No
Are you sick today? If yes, list your symptoms: _____	☐	☐
Have you or anyone in your household been exposed to, diagnosed with, or has been placed in quarantine for COVID-19 in the past 14 days?	☐	☐
Have you received passive antibody therapy as treatment for COVID-19 in the past 90 days?	☐	☐
Have you received any vaccinations in the past 2 weeks? If yes, please list: _____	☐	☐
Have you ever had a severe allergic reaction (anaphylaxis) to any medications, latex, foods, pets or insects that required the use or treatment with epinephrine (EpiPen)? If yes, please list allergies: _____ *Moderna: must be observed for 30 minutes post-vaccination	☐	☐
Do you have an underlying medical condition like liver, kidney, heart disease, diabetes, or are immunocompromised?	☐	☐
Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐
For women: Are you currently pregnant?	☐	☐

I, the undersigned, hereby acknowledge that I have received the Emergency Use Authorization (EUA) vaccine sheet. I have had the opportunity to ask questions for the immunization to be administered to me or the person named above, for whom I am authorized to make this request. I agree to allow my immunization information to be stored and accessed by authorized users in Nevada's WebIZ. I voluntarily request that the vaccine be given to me or for the aforementioned person for whom I am authorized to make this request. By signing this document, I declare that the above information is true and accurate to the best of my knowledge.

☐ I authorize the vaccine to be administered by a trained student pharmacist.

Signature: _____ Date: _____

If under 18, print name of parent, guardian or caregiver: _____

Vaccine	Lot #	Exp Date	Route	Site	Dose	Date Given	Administered by:
Moderna (MOD)			IM	LD or RD	0.5 ml		
Pfizer (PFR)			IM	LD or RD	0.3 ml		
Johnson/Johnson			IM	LD or RD	0.5 ml		

☐ Entered into WebIZ

Please see backside

COMMUNITY HEALTH ALLIANCE

Vaccine Informed Consent (COVID) - Demographic Information

Patient Information
First Name: _____ Last Name: _____ Date of Birth: _____

Ethnicity	Race
Please check *all applicable* boxes: □ Hispanic or Latino □ Non-Hispanic or Non-Latino □ Not Known	Please check *all applicable* boxes: □ Asian □ Black □ Native Hawaiian or Pacific Islander □ White □ Other □ Mixed □ Unknown

Personnel Groups: Please check ***one*** of the groups below that best describes you:

Please check *all applicable* boxes:

□ Migratory/Seasonal Agriculture Workers

□ Individuals Experiencing Homelessness

□ Resident of Public Housing

□ Individual with Limited English Proficiency

□ None of the above