COVID-19 Vaccine Administration Record & Informed Consent

Patient's Name_____ **Birth Date:** _____/____/_____ **Age:** _____
Last First Middle Month/Day/Year

Street Address:_____
APT # CITY STATE ZIP CODE

Phone Number : _____ **Gender:** ☐ Female ☐ Male **Transgender:** ☐ Female to Male ☐ Male to Female

Language most comfortable speaking: _____ **Do you need an interpreter?** ☐ Yes ■ No
Hearing impaired or need sign language interpreter services? ☐ Yes ■ No

Race: Check all that apply	☐ African American/Black ☐ Asian ☐ Caucasian/White (inc Hispanic) ☐ Other_____ ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native ☐ Prefer not to answer	**Ethnicity:** Check One	☐ Non- Hispanic ☐ Hispanic/Latino ☐ Prefer not to answer

Patient Emergency Contact: (For emergency only such as passing out or needing to be taken to a hospital)
Name _____ **Relationship:** _____**Phone Number:** _____

CHECK ONE ONLY: ☐ General Medical/Surgical Staff ☐ Long Term Care Staff/Residents ☐ Pharmacists/Pharmacy Techs
☐ Psychiatric/Substance Abuse Hospitals ☐ Outpatient/Ambulatory/Home Health Providers ☐EMS Personnel
☐ Laboratory Staff ☐ Public Health Workforce/Volunteers ☐ Law Enforcement/Public Safety
☐ Deployed/Mission Critical Staff ☐ State or Local Emergency Ops. Managers/Staff ☐ Nevada Dept of Corrections

Please answer the questions below to help us determine if there is any reason you should not get the COVID-19 vaccine today.
If you need help, please ask a staff person.

IS THE PERSON RECEIVING THE COVID 19 VACCINE:	Yes	No	Don't Know
1. Feeling sick today?			
2. Ever received COVID Vaccine before? If yes, what product? ☐ Pfizer ☐ Moderna ☐ Other			
3. Ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen® or that you had to go to the hospital?			
• Was the severe allergic reaction after receiving a COVID-19 vaccine?			
• Was the severe allergic reaction after receiving another vaccine or injectable medication?			
4. Received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
5. Received <u>any vaccine</u> within the past 14 days?			
6. Ever had a positive test for COVID-19 or had a doctor ever told you that you had COVID-19?			
7. Have a weakened immune system caused by something such as HIV infection or cancer or take immunosuppressive drugs or therapies?			
8. Have a bleeding disorder or taking a blood thinner?			
9. FOR FEMALES 9 years old or older: Are you pregnant or breastfeeding?			

Informed Consent: *I answered all the questions correctly to the best of my knowledge. I have read or have had explained to me the information contained in the EUA Fact Sheet or VIS about COVID 19 disease/vaccine. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the vaccine and request this vaccine be given to me or to the person named above for whom I am authorized to make this request. I answered all the questions correctly to the best of my knowledge.*
I ACKNOWLEDGE THAT A COPY OF THE "NOTICE OF PRIVACY PRACTICE" HAS BEEN MADE AVAILABLE TO ME.

SIGN HERE: _____ **Date:** _____
☐Self ☐Parent/Guardian

AREA BELOW FOR SNHD STAFF ONLY

Vaccine	Date Given	Dose #	Mfg & Lot #	Site	Route	EUA/VIS Date	Administered & Reviewed by:
COVID-19				LA LT RA RT	IM	Moderna 12/2020 Pfizer 12/2020	

NV Web IZ Record # _____ EUA Confirmed by (Initials) _____ Data Entry by (Initials): _____

Clinic Location: ☐Main ☐ELV ☐Hend ☐Mesquite ☐Other _____