

Name (as it appears on insurance card): _____ Date of Birth: _____ Age: _____ Gender: Male / Female

Street Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ @ _____ Phone Number: _____

Please contact me about screenings, immunization clinics and other promotions.

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African American ☐ Native American /Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other

MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine.

If you answer "YES" to any question, it does not necessarily mean you should not be vaccinated.

Section 1:	*YES	NO
<i>*If YES and further guidance is needed, refer to Pfizer website at www.PfizerMedInfo.com or call 1-800-438-1985 for vaccine information on vaccine temperature excursions, efficacy, safety, stability, dosage, vaccine ingredients, mechanism of action and administration. For overview for Vaccination Providers about Moderna COVID-19 vaccine refer to www.modernatx.com or call 1-866-MODERNA.</i>		
1. Are you feeling sick today?		
2. Have you ever received a dose of COVID-19 vaccine?		
• If yes, which vaccine product did you receive? <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> Janssen (Johnson & Johnson) <input type="checkbox"/> Another Product		
• Have you received a complete COVID-19 vaccine series? (i.e., 1 dose Janssen or 2 doses of an mRNA vaccine [Pfizer-BioNTech, Moderna])?		
• Did you bring your vaccination record card or other documentation?		
3. Have you ever had an allergic reaction to:		
(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)		
• A component of a COVID-19 vaccine, including either of the following:		
◦ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures		
◦ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids		
• A previous dose of COVID-19 vaccine		
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication?		
(This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that caused hives, swelling, or respiratory distress, including wheezing.)		
5. Check all that apply to you:		
<input type="checkbox"/> Am a female between ages 18 and 49 years old		
<input type="checkbox"/> Am a male between ages 12 and 29 years old		
<input type="checkbox"/> Have a history of myocarditis or pericarditis		
<input type="checkbox"/> Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies		
<input type="checkbox"/> Had COVID-19 and was treated with monoclonal antibodies or convalescent serum		
<input type="checkbox"/> Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection		
<input type="checkbox"/> Have a bleeding disorder		
<input type="checkbox"/> Take a blood thinner		
<input type="checkbox"/> Have a weakened immune system (i.e., HIV infection, cancer) or take immunosuppressive drugs or therapies		
<input type="checkbox"/> Have a history of heparin-induced thrombocytopenia (HIT)		
<input type="checkbox"/> Am currently pregnant or breastfeeding		
<input type="checkbox"/> Have received dermal fillers		
<input type="checkbox"/> History of Guillain-Barré Syndrome (GBS)		
Section 2: RELEASE AND ASSIGNMENT:		
<ul style="list-style-type: none"> I have read or had explained to me the Vaccine Recipient Emergency Use Authorization (EUA) Fact Sheet for COVID-19 vaccine risks and benefits. To read the Vaccine Recipient Emergency Use Authorization Fact Sheet for each vaccine visit the website www.cvdvaccine.com: or you may also visit the Local Health Unit or private provider to receive a printed copy of the EUA Fact Sheet. To read the Vaccine Recipient Emergency Use Authorization for Moderna COVID-19 vaccine visit the website https://www.fda.gov/media/144638/download or (modernatx.com) I give consent to this COVID-19 provider/staff for the individual named below to be vaccinated with COVID-19 vaccine. I hereby acknowledge that I have reviewed a copy of the Provider's Privacy Notice. I understand that information about this COVID-19 vaccination will be included in (SIMON) South Carolina Immunization Information System. 		
To My Insurance Carrier(s):		
<ul style="list-style-type: none"> I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to this COVID-19 Provider. I agree that the authorization will cover all medical services rendered until I revoke the authorization. I agree that the photocopy of this form may be used instead of the original. 		

My signature below indicates I have read, understand and agree to section 2. **Release and Assignment** of the COVID-19 Immunization Consent Form and Vaccine Recipient Emergency Use of Authorization Fact Sheet (EUA).

Signature of patient or guardian X: _____ Date: _____

Below is for pharmacy documentation

<input type="checkbox"/> Pfizer-BioNTech (Dose: 0.3 ML) <input type="checkbox"/> Moderna (Dose: 0.5 ML) <input type="checkbox"/> Janssen/J&J (Dose: 0.5 ML)	Route <input type="checkbox"/> IM	Site Code <input type="checkbox"/> LA <input type="checkbox"/> RA	Lot Number:
MFG Codes: PFR=Pfizer, MOD=Moderna, ASZ=AstraZeneca, JSN=Janssen, NVX=Novavax, MSD=Merck Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA			

Administered by: _____ Title: _____ Date Given: _____