PLEASE PRINT		
Last Name:	First Name:	Date of Birth:
Address:	City:	State: Zip:
Phone #:	Email:	

1. What is your race?
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ White
   - ☐ Multi-Racial or other (please specify) _____
   - ☐ Latino or Hispanic origin
   - ☐ Decline to answer

2. Vaccine Dose (check one): 1st ☐ 2nd ☐ If this is your second dose, what vaccine was your first?
   Pfizer ☐ Moderna ☐ Don't know ☐
   If this is your second dose, when did you receive your first dose? (date): _____.

	YES	NO
EXCLUSION QUESTIONS: Answering yes to this question excludes 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 such as lipids, potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, 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.)	☐	☐
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		
1. In the past 90 days have you received passive antibody therapy as part of COVID-19 treatment? Keep	☐	☐
2. 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 to food, latex, pet, environmental, or medication allergies that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐
3. Have you ever had a serious reaction after receiving an injectable medication? If yes, what injectable medication: _____	☐	☐
4. Do you have a history of fainting, particularly with vaccines? Has any physician or other health care provider ever cautioned you about receiving certain vaccines or receiving vaccines outside of a medical setting?	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, or any other immune system problem? Do you have a weakened immune system or in the past three months, taken medications that weaken it, such as cortisone, prednisone, or other steroids, anticancer drugs, immunosuppressive drugs or therapies, or radiation treatments?	☐	☐
6. For women, are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐
7. Have you received any vaccinations in the past two weeks?	☐	☐

Acknowledgements:

- I made the choice to get the COVID-19 vaccine on my own and freely. I know I have the option to refuse the vaccine. I ask that the vaccine be given to me, or to the person named above for whom I can make this request. I was given the (Fact Sheet for Vaccine Recipients and Caregivers) for this vaccine. The fact sheet has information about side effects and adverse reactions. I read or had read to me the information provided about the COVID-19 vaccine.
- I know the Food and Drug Administration (FDA) has authorized the emergency use of this vaccine. I know it is not a fully licensed FDA vaccine. I had the chance to ask questions that were answered to my satisfaction. I now know about the vaccine, alternatives, benefits, and risks, to the extent they are known and unknown at this time.
- I know that I must stay in the vaccine area or an area told to me by my health care provider after I receive my immunization so I am near my health care provider if I have any adverse reactions. If I have a history of

severe allergic reaction, (e.g. anaphylaxis), I must stay for 30 minutes. If I do not have a history of severe allergic reaction, I must stay for 15 minutes.

- I understand if I experience side effects after leaving the vaccine area that I should do the following: call Mason Health, my doctor, or call 911.
- I know that if I have a severe allergic reaction, including difficulty breathing, swelling of my face and/or throat, a fast heartbeat, a bad rash all over my body or dizziness and weakness I should call 9-1-1. I know I can call my health care provider if I have any side effects that bother me or do not go away.
- I know I must get two doses of the COVID-19 vaccine and receive the same vaccine each time. I know that with all vaccines there is no promise I will become immune (not get the virus) or that I will not have side effects. I know I may choose to not get the second dose of the vaccine. But if I do not get the second dose, the chance that I will become immune may go down.

Disclosure of Records: Mason Health may be required to or may voluntarily disclose my health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries, for purposes of treatment, payment or health care operations.

Signature of patient (or authorized representative):	Date/Time:
Printed name if signed on behalf of patient (notation, if any, by staff):	
Follow-up Vaccine Appointment Date:	

For Office use only			
Vaccine:	Covid-19 Vaccine	**Date on VIS:**	☐ **1st Dose**
Date Given:	**Time Given:**	**Injection Site**	Left Right
Manufacturer, Lot #, Exp. Date		**Nurse Signature:**	
		Date:	

Signature of patient (or authorized representative):	Date/Time:
Printed name if signed on behalf of patient (notation, if any, by staff):	

For Office use only			
Vaccine:	Covid-19 Vaccine	**Date on VIS:**	☐ **2nd Dose**
Date Given:	**Time Given:**	**Injection Site**	Left Right
Manufacturer, Lot #, Exp. Date		**Nurse Signature:**	
		Date:	