COVID VACCINE INTAKE FORM

Patient Information (please print)
Last Name: _____ First Name:_____ Male ____ Female ____
Phone #: __ __ __ -- __ __ __ -- __ __ __ __
Date of Birth: ___ / ___ / ___ Current Age _____
Street Address: _____
City: _____ State: _____ Zip Code : _____ Email: _____

Please answer the following questions for the person receiving the COVID vaccine today (circle yes or no):

1. Are you feeling sick today?	NO / YES
2. Have you ever received a dose of COVID vaccine in the past?	NO / YES
3. Have you 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 for which you had to go to the hospital?	NO / YES
4. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	NO / YES
5. Have you received another vaccine in the last 14 days?	NO / YES
6. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	NO / YES
7. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	NO / YES
8. Do you have a bleeding disorder or are you taking a blood thinner?	NO / YES
9. Are you pregnant or breastfeeding?	NO / YES

Clinic Use Only:

Vaccine	Date Administered	Vaccine Manufacturer	Vaccine Lot number	Site Given	Signature & Title of Vaccine Administrator
COVID 19 Vaccine		Moderna		L R Deltoid	

COVID 19 IMMUNIZATION CONSENT FORM
Consent to Healthcare Services

I am authorizing Dr. Milner to provide health services to me, my child, or the client named above. I am also aware that healthcare services often involve risk and no guarantee has been made to me about the results of treatment. If I am receiving vaccine(s), I will receive a copy and be given the chance to read (or have read to me) the information contained in the appropriate Vaccine Information Statement (or COVID 19 information equivalent issued by the CDC) about the disease(s) and vaccine(s) to be administered. I will ask questions if needed and notify staff members if I need additional information. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) recommended be given to me or the person named above for whom I am authorized to make this request.

Vaccine Data Release to State of Ohio Immunization Registry
Dr. Milner participates in the Ohio Immunization Registry known as IMPACT SIIS. Following administration of the vaccine the visit information will be uploaded to the system. This allows state and federal health officials to track vaccine efforts and also allows other health care providers to view your current immunization status.

_____ _____
Signature of client or responsible party Date

_____ _____
Printed name of responsible party if not the client (if applicable) Relationship to client (if applicable)