El Dorado County Public Health COVID-19 Vaccine Registration and Consent

Patient's Name_____ **Age**_____ **Date of Birth** _____
LAST FIRST MM/DD/YY

Gender: ☐ **Male** ☐ **Female** ☐ **Unknown** ☐ **Decline to State**

Health Insurance Provider:

Email Address_____

Mailing Address_____**City**_____**Zip**_____

Mother's Maiden Name_____ **Preferred Phone #** ( )_____-_____

PATIENT HEALTH SCREENING QUESTIONS

Yes	No	
☐	☐	1. Are you feeling sick today?
☐	☐	2. Have you ever received a dose of COVID-19 Vaccine? If so, was it ___Pfizer ___Moderna ___Another Product
☐	☐	3. Have you ever had a severe allergic reaction (e.g. anaphylaxis) where you were treated with an EpiPen or epinephrine or had to go to the hospital?
☐	☐	a. If so, was the severe allergic reaction after receiving the COVID-19 Vaccine?
☐	☐	b. If so, was the severe allergic reaction after receiving another vaccine or another injectable medication?
☐	☐	4. Have you had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?
☐	☐	a. If so, have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as a treatment for COVID-19?
☐	☐	5. Have you received another vaccine in the last 14 days?
☐	☐	6. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?
☐	☐	7. Do you have a bleeding disorder or take a blood thinner?
☐	☐	8. Are you pregnant or breastfeeding?
☐	☐	a. If I am pregnant or breastfeeding, I understand that there is no data regarding risks to pregnancy and baby post COVID-19 vaccine and the best source of risk information is my medical provider.

I have received the "EUA (Emergency Use Authorization) Fact Sheet for Recipients". I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine. I understand that I can call El Dorado County Public Health if I have any questions regarding the vaccine received.

Date: _____ Patient Signature _____

Date: _____ Parent/Guardian Signature_____

Date: _____ Reviewed By Signature_____

SECTION BELOW COMPLETED BY STAFF ONLY

PATAGONIA OR CAIR #___

Date	Circle Site/ Route	Lot # / Expiration Date	Vaccine Description, Manuf. & Licensure	CVX Code	CPT Code
	RD/IM LD/IM		**Moderna** COVID-19 Vaccine	N/A	N/A
	RD/IM LD/IM		**Pfizer**-BioNTech COVID-19 Vaccine	N/A	N/A
	RD/IM LD/IM				

Administered by: Name and Title	**Clinic Location:** El Dorado County Public Health
	Comments: