original

2021 COVID-19 VACCINE

DATE 今天日期: ____/____/_____

PATIENT'S NAME 姓名: _____ DOB 出生日期: ____/____/_____

PRIMARY CARE PHYSICIAN 家庭醫生: _____ PHONE 電話: _____

Any contraindications?

Y_ N _ have any allergies 有過敏史?

Y _N _ have a fever, sick tody 今天發燒, 生病嗎?

Y_ N _ Have you been tested positive or been diagnosed with COVID-19 in the last 90 days

在過去90天內, 你有沒有被確診過陽性COVID-19

Y_ N _ have a bleeding disorder or are on a blood thinner 患有出血性疾病或正在服用血液稀釋劑

Y_ N _ are immunocompromised or are on a medicine that affects your immune system

免疫功能衰弱或者正在使用會影響您的免疫系統的藥物

Y_ N _ are pregnant or plan to become pregnant 懷孕了? 或打算懷孕

Y_ N _ are breastfeeding 現在是哺乳期

Y_ N _ have received 1st dose of COVID-19 vaccine 已接種第一劑COVID-19疫苗

Y_ N _ had a severe allergic reaction after a previous dose of this vaccine 先前接種該疫苗後有嚴重的過敏反應

Y_ N _ had a severe allergic reaction to any ingredient of this vaccine 對這種疫苗的任何成分有嚴重的過敏反應

Y_ N _ no any vaccine within 14 days 14天內未接種任何疫苗

Y_ N _ severe reaction to any previous vaccine: list- _____ 對其他的疫苗有嚴重反應

PATIENT SIGNATURE: 患者簽名 _____

ROUTE: LEFT/RIGHT ARM IM 左/右 臂

PATIENT INFORMATION *(Please print clearly)*

Last Name: 姓	First Name: 名	MI:	D.O.B.: 出生日期	Age: 年齡	Gender: 性別
Race/ Ethnicity: 種族	American Indian/Alaska Native	Black/African American	Hispanic/Latino		
	Native Hawaiin/Other Pacific Islander	White 白人	Asian 亞洲人	Other 其他族	
Home Address: 地址			Contact Phone: 電話		
City: 城市	State: 州		Zip: 郵政号碼		
Primary Care Physician: 家庭医生			Physician Phone: 医師电話		
Physician Address: 医生地址			Physician Fax #: 医生传真		

I certify that I am: (a) the patient and at least 18 years of age or (b) the parent or legal guardian of the patient. Further, I hereby give my consent to the healthcare provider of "_____", to administer the vaccine(s) I have requested above. I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that I understand the purposes/benefits of my state's immunization registry ("State Registry") and the Provider may disclose my immunization information to the State Registry. I acknowledge that, depending upon my state's law, I may prevent the disclosure of my immunization information by the applicable Provider to the State Registry by using the opt-out form. The Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and to the extent required by my state's law, by signing below I hereby do consent to the Provider reporting my immunization information to the State Registry. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information as required or permitted by law. I voluntarily authorize and direct my healthcare provider at "_____" to use or disclose my health information during the term of this Authorization to the physician responsible for this protocol of specific health information of people vaccinated at "_____", my Primary Care Physician, my insurance and/or state or federal registries, where required, for the purpose of treatment, payment or other healthcare operations. I further agree to be fully financially responsible for any cost sharing amounts, including copays, coinsurance, and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service.

PATIENT NAME: _____
名字： *(Please print clearly)*

PATIENT SIGNATURE: _____ **DATE:** _____
簽名： *(Parent or guardian, if minor)* 日期