**ASSURED HEALTH**

**8421 W. Broadway Ave, Brooklyn Park, MN 55445**

**Health History**

Talk to your health care provider prior to vaccination if you answer yes to any of the following:

| **Yes** | **No** | **Unknown** | **Question** |
| --- | --- | --- | --- |
| Yes | No | Unknown | Severe allergic reaction (e.g., anaphylaxis) to a previous dose of mRNA COVID-19 vaccine or any of its ingredients? |
| Yes | No | Unknown | Immediate allergic reaction of any severity within 4 hours to a previous mRNA COVID-19 vaccine dose or any of its ingredients (including polyethylene glycol [PEG])? |
| Yes | No | Unknown | Immediate allergic reaction of any severity to polysorbate? |
| Yes | No | Unknown | History of any immediate allergic reaction to any other vaccine or injectable therapy (e.g., shots in the muscle (intramuscular), in the vein (intravenous), or into the fatty tissue (subcutaneous) or therapies not related to a mRNA COVID-19 vaccine ingredient or polysorbate)? |
| Yes | No | Unknown | Are you feeling sick today? |
| Yes | No | Unknown | Received monoclonal antibodies or convalescent plasma as part of COVID-19 treatment in the past 90 days? |
| Yes | No | Unknown | Exposed to another person with known COVID-19 disease? |
| Yes | No |  | Have you ever received a dose of COVID-19 vaccine?  If yes, list vaccine product and date received: |
| Yes | No | Unknown | Have you received any other vaccines (that were not COVID-19 vaccine) within the past 14 days? |
| Yes | No | Not applicable | Are you pregnant? |

By signing below, I understand, recognize, approve, and agree that:

* I have received and read or had explained to me the Emergency Use Authorization Fact Sheet for the following COVID-19 vaccine: MODERNA (8804) OR JANSSEN (8806). Please read the EUA of the vaccination you are taking.
* I have had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the COVID-19 vaccine as described.
* I agree to receive the COVID-19 vaccine for myself or for the person named above.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or parent/guardian:

Date: / / 2021