**Patient Information**

**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Birth date:** \_\_\_/\_\_\_/\_\_\_\_\_ **Age:** \_\_\_\_ **Sex:** ☐ M ☐ F

**Race:**  ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_ **Zip:** \_\_\_\_\_\_\_\_\_\_\_

**Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Vaccine Requested:** ☐ COVID-19 ☐ Flu

**Do you have insurance?** 🞎Yes 🞎No **Insurance Company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **RX BIN:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **RX PCN:** \_\_\_\_\_\_\_\_\_\_\_\_

**RX Group: \_\_\_\_\_\_\_\_\_ RX ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relation to Subscriber:** \_\_\_\_\_\_\_\_\_\_ **Person Code:** \_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Screening Questions** | **Yes** | **No** |
| Are you sick today? |  |  |
| Do you have a serious allergy to any medication, food, pet, environmental allergens, oral medications, or latex? If yes please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Have you ever had a serious reaction or fainted after receiving a vaccine? |  |  |
| Have you received a dose of COVID-19 vaccine?If Yes which product ☐ Pfizer ☐ Moderna ☐ J&J ☐ Other Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Have you received passive antibody therapy as treatment for COVID-19 in the past 90 days? |  |  |
| Do you have a seizure or brain disorder? |  |  |
| Do you have a medical condition or take any medications that may weaken your immune system?If yes please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Are you of 50 years of age or older? |  |  |
| Are you between the ages of 18 and 64 and have frequent institutional or occupational exposure to SARS-CoV-2 that puts you at high risk of serious complication of COVID-19 including COVID-19? |  |  |
| For women: Are you pregnant or breastfeeding? |  |  |

* If I have health insurance that covers myself or the child named above, I give permission for my insurance company to be billed for the costs of administering the vaccine being administered. The government is paying for the COVID-19 Vaccine itself, and I will not be billed for that portion of the cost of my immunization. If I am receiving a vaccine other than a COVID-19 vaccine I may be billed for the amount not covered by insurance
* I have received the Patient Privacy Notices regarding the use of my information for treatment, payment, or healthcare operations
* I understand that as required by state law, all immunizations will be reported to the Department of Public Health Massachusetts Immunization Information System (MIIS). I can access the MIIS Fact Sheet for Parents and Patients, at www.mass.gov/dph/miis, for information on the MIIS and what to do if I object to my or my family’s data being shared with other providers in the MIIS.
* I have read, or have had explained to me, the Emergency Use Authorization (EUA) for COVID-19 vaccine or Vaccine Information Statement (VIS) for other vaccines that I will be receiving and had had an opportunity to ask any questions about the vaccines
* I have been advised to wait 15-30 minutes for observation after the administration of the vaccine

**Please print name of signature if different from person receiving vaccine** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient or Parent/Guardian Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Pharmacy Use Only Below

|  |  |  |
| --- | --- | --- |
| **Date Given/EUA Date** |  |  |
| **Vaccine, Lot#, Dose** |  |  |
| **Clinic location** |  |  |
|  |  |  |
| **Admin Site (circle one)** | **Left Deltoid or Right Deltoid** | **Left Deltoid or Right Deltoid** |

**Signature of Vaccine Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_