

Nothing is required to receive a vaccine. When applicable, have your vaccine card & insurance card available.

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____ / ____ / ____ Age: _____ years Gender: M / F

Address (including city, state, zip): _____

E-mail: _____ Phone #: _____ - _____ - _____

Which dose are you receiving today?

- 1st Dose
- 2nd Dose
- Booster Dose (Please select which manufacturer)
 - Pfizer:**
 - Must be at least 12 years old (Pfizer only) **AND**
 - 5 months after previous Pfizer dose **OR** 6 months after previous Moderna **OR** 2 months post J&J dose
 - Moderna** (only available at Lutheran Medical Center)::
 - Must be at least 18 years old **AND**
 - 5 months after previous Pfizer dose **OR** 6 months after previous Moderna **OR** 2 months post J&J dose
- Additional primary dose at 28 days if immunocompromised* -must be at least ≥12 yrs for Pfizer or ≥18 yrs for Moderna

Date of last dose: _____ Brand of previous dose(s): Pfizer Moderna J&J Unknown N/A

Yes	No	General Questions (Please review and complete the <u>day of the vaccine</u>)
		Are you currently ill?
		Have you received treatment for COVID-19 with convalescent plasma or a monoclonal antibody (bamlanivimab or casirivimab/imdevimab) in the last 90 days?
		Have you ever had an anaphylactic reaction (i.e. swelling of throat or mouth, difficulty swallowing, sudden drop in blood pressure) to a vaccine or other injectable medication?
		Have you ever had an anaphylactic reaction (i.e. swelling of throat or mouth, difficulty swallowing, sudden drop in blood pressure) to ANY medication or other allergen (i.e food, environmental)? NOTE: if yes - you will be observed for 30 min following administration
		Did you have any serious side effects following a previous dose of COVID-19 vaccine (myocarditis, anaphylaxis, etc)?
		Are you at higher risk of bleeding due to a bleeding disorder or use of an anticoagulant medication?
		* Do you have any of the following conditions that suppress immunity? (Please mark those that apply) <ul style="list-style-type: none"> <input type="checkbox"/> <u>Active</u> cancer treatment for tumors or cancers of the blood <input type="checkbox"/> Received an organ transplant and are taking medicine to suppress the immune system <input type="checkbox"/> Received stem cell transplant within the last 2 years or are taking medicine to suppress the immune system <input type="checkbox"/> Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome) <input type="checkbox"/> Advanced or untreated HIV infection <input type="checkbox"/> Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response

I fully understand and agree to all of the following:

- The COVID-19 vaccine is voluntary. I am making a voluntary request to receive the COVID-19 vaccine.
- I understand that a record of my COVID-19 vaccine administration will be entered into the SCL Health Electronic Health Record, Epic, and COVID-19 vaccine administration records will be able to be viewed by others just like the rest of my Epic medical record.
- I understand that SCL Health may be required by law to report my administration information and basic data to the state vaccine registry and CDC and I consent to SCL Health doing so.
- I understand that I am giving SCL Health permission to release any medical or other information necessary to my physician, my insurance including Medicare, or immunization registry, and as applicable, I authorize SCL Health to process my insurance claims with respect to this vaccination.
- I have received and reviewed the Emergency Use Authorization (EUA) Fact Sheet plus any additional COVID-19 vaccine information that has been provided to me by SCL Health. I understand all of the listed potential risks and benefits of the vaccine and accept the risks and wish to receive a vaccine today.
- I have had a chance to ask questions and all of my questions have been answered to my full satisfaction.
- I attest that all information provided on this form is accurate to the best of my knowledge.

Patient/Guardian Signature

Date v1062022