First Name: ____________ Last Name: ____________ Date of Birth: ________

Phone Number:________________________ Observation Time: __________

For patients: Information collected on this form will be used to determine if there is any reason you should not get the COVID-19 vaccine today. If you answer "yes" to any of the questions, it does not necessarily mean you should not be vaccinated. This means additional questions may be asked.

		Yes	No	Unsure
1.	Are you moderately or severely ill today (cough, sore throat, or runny nose, shortness of breath or trouble breathing, chills, muscle aches or diarrhea)?	☐	☐	☐
2.	Do you have a **NEW** loss of smell or taste or any change in taste?	☐	☐	☐
3.	Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
4.	If answered yes to question 3, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Other:______________________________			
5.	If answered yes to question 3, did you have an allergic reaction to the previous dose of vaccine? (Includes a severe reaction (anaphylaxis) that required treatment with epinephrine or required a hospital visit. This also includes an allergic reaction that occurred within 4 hours that caused hives, swelling, respiratory distress, or wheezing)	☐	☐	☐
6.	Have you ever had an allergic reaction to a component of a COVID-19 vaccine (polyethylene glycol (PEG) which is found in some medications (laxatives and preparations for colonoscopy procedures) or polysorbate which is found in some other vaccines, film coated tablets, or intravenous steroids)?	☐	☐	☐
7.	Have you ever had a severe allergic reaction due to any cause? (Includes food, pet, venom, environmental, injections, or oral medications)	☐	☐	☐
8.	Have you received medication to treat COVID-19 (ex: Regeneron, bamlanivimab/etesevimab, or convalescent plasma) in the last 90 days?	☐	☐	☐
9.	Check all that apply to you: ☐ Am a female between ages 18 and 49 years old ☐ Am a male between ages 12 and 29 years old ☐ Have a history of myocarditis or pericarditis ☐ Diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A) after a COVID-19 infection ☐ Am currently pregnant or breastfeeding ☐ Take immunosuppressive drugs or therapies ☐ Have a weakened immune system (ex: HIV infection, cancer) ☐ Have a bleeding disorder or take a blood thinning medication ☐ Have a history of heparin-induced thrombocytopenia (HIT) ☐ Have received dermal fillers			
10.	This is my ☐ Booster Dose (≥6 mths from 2nd dose) ☐ Additional Dose(≥28 days from 2nd dose) ☐ None			
11.	Have many doses of COVID-19 vaccine have you received (circle one)	0	1	2
12.	Date of the Last Dose:__________________________			

CONSENT TO RECEIVE SERVICES: I have been provided the VSAFE information and the Emergency Use Authorization Fact Sheet for the vaccine that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the risks and benefits of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

PAYMENT AUTHORIZATION: I do hereby authorize Reedsburg Area Medical Center to release information and request payment for administration of the vaccine. I certify that the information given by me in applying for payment is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

____ ______________________________

Signature of patient/legal guardian Date

For immunizer use only(do not complete):

Vaccination	Manufacturer	Lot and Expiration Date	Site of Immunization	EUA Date
COVID-19 Vaccine	☐ Moderna		L or R Deltoid via IM	8/2021
	☐ Pfizer-BioNTech			9/2021
	☐ Janssen (Johnson & Johnson)			8/2021

Provider signature: ____Date:_________________

☐ **Entered in WIR**

Updated 10/8/21