PLEASE PRINT		
Last Name:	First Name:	Date of Birth:
Address:	City:	State: Zip:
Phone #:	Email:	
Gender:		
Are you employed by Mason Health?	YES ☐ NO ☐	

1. What is your race?
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ White
   - ☐ Multi-Racial or other (please specify) _____
   - ☐ Latino or Hispanic origin
   - ☐ Decline to answer

2. Have you been vaccinated against Covid-19 before? ☐ Yes ☐ No

   If yes and age is ≥ 5 years, was the last dose more than 2 months ago? ☐ Yes ☐ No

   If yes and age is < 5 years, immunizer should refer to CDC guidelines for current recommendations based on vaccination history.

	YES	NO
EXCLUSION QUESTIONS: Answering yes to this question excludes you from receiving the vaccine.		
Do you have a known history of a severe allergic reaction (e.g., anaphylaxis) to this vaccine or any components of the vaccine such as lipids, potassium chloride, monobasic potassium phosphate, sodium chloride, dibasic sodium phosphate dihydrate, tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate and sucrose? (Full list is available in the *Fact Sheet for Vaccine Recipients and Caregivers* or from your health care provider.)		
SCREENING QUESTIONS: Immunizer: If patient answers "yes" to any of the below, provide patient counseling or instruct them to consult with their caregiver prior to receiving the vaccine		
1. In the past 90 days have you received passive antibody therapy as part of COVID-19 treatment?		
2. Have you ever had an allergic reaction to another vaccine or medication injection? Have you had an allergic reaction to other medication, food, latex, animals or environmental allergens that caused hives, swelling, difficulty breathing, or wheezing?		
3. If you answered yes to #2, did any reactions require treatment with epinephrine (Epi-Pen) or cause you go to the hospital?		
4. Have you ever had a serious reaction after receiving an injectable medication? If yes, what injectable medication: _____		
5. Do you have a history of fainting, particularly with vaccines? Has any physician or other health care provider ever cautioned you about receiving certain vaccines or receiving vaccines outside of a medical setting?		
6. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, or any other immune system problem? Do you have a weakened immune system or in the past three months, taken medications that weaken it, such as cortisone, prednisone, or other steroids, anticancer drugs, immunosuppressive drugs or therapies, or radiation treatments?		
7. Have you tested positive for COVID-19 in the past 14 days?		

Acknowledgements:

- I know that I must stay in the vaccine area or an area told to me by my health care provider after I receive my immunization, so I am near my health care provider if I have any adverse reactions. If I have a history of severe allergic reaction, (e.g., anaphylaxis), I must stay for 30 minutes. If I do not have a history of severe allergic reaction, I must stay for 15 minutes.
- I understand if I experience side effects after leaving the vaccine area that I should do the following: call Mason Health, my doctor, or call 9-1-1.
- I know that if I have a severe allergic reaction, including difficulty breathing, swelling of my face and/or throat, a fast heartbeat, a bad rash all over my body or dizziness and weakness I should call 9-1-1. I know I can call my health care provider if I have any side effects that bother me or do not go away.

Patient Label

- It is recommended to get all doses with the same manufacturer. I know that with all vaccines there is no promise I will become immune (not get the virus) or that I will not have side effects. I know I may choose not to get additional doses of the vaccine. I understand if I do not get the additional doses, the chance that I will become immune may go down.

Disclosure of Records: Mason Health may be required to or may voluntarily disclose my health information to my primary care physician, my insurance plan, health systems and hospitals, and state or federal registries, for purposes of treatment, payment, or health care operations.

Signature of patient (or authorized representative):	Date/Time:
Printed name if signed on behalf of patient (notation, if any, by staff):	

For Office use only			
Vaccine:	Covid-19 Vaccine	**Date on VIS:**	
Date Given:	**Time Given:**	**Injection Site**	Left Right
Manufacturer, Lot #, Exp. Date		**Nurse Signature:**	
		Date:	