COVID-19 Vaccination Form

Patient's Name: ………………….. Date of Birth:……………………. Gender:

Phone Number: ……………………

Address:……………………………………………………………………………………………….

Insurance/ Group ID/ Member ID…………………………………………………………………….

Are you sick today? ☐ Yes ☐ No

Do you have allergies to medications, food, a vaccine component, or latex? ☐ Yes ☐ No

Have you had a serious reaction to a vaccine in the past? ☐ Yes ☐ No

Have you had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? ☐ Yes ☐ No

Do you use Tobacco or e-cigarettes? ☐ Yes ☐ No

Have you received vaccinations in the past 4 weeks? ☐ Yes ☐ No

For women- Date of last Menstrual cycle? …………….. Birth control method? ……………

I understand that the Covid vaccine may have unknown side effects or adverse effects currently unknown to healthcare providers. The Covid vaccine has been authorized under a federal emergency authorization and therefore the provider has no liability for the complications, side effects and adverse effects of the covid vaccine.

I consent to the administration of the vaccine to be given. A copy of the Vaccine Information Statement has been provided. I have read the information about the vaccine and I had an opportunity to ask questions and believe I understand the benefits and risks of the vaccine.

I understand that University Place Medical Clinic is required to report Vaccine administration information to the Washington Immunization Information System (WAIIS)

Patient's Signature: ……………………………………………Date: …………………………….