COVID-19 Vaccine Worksheet

Name _____ DOB: _____
Address _____ _____Age: _____
City _____ State ____ Zip Code _____ Telephone _____ Gender: _____
Insurance Name: _____ID #_____ Group #_____
Insured Name: _____ Email address: _____

Vaccine Data Collection Questions	Yes	No
Are you Hispanic/Latino?		
What is your Race? White ☐ Black/African American ☐ Asian ☐ Hawaiian Native ☐ Pacific Islander ☐ American Indian/Alaskan ☐ Other ☐		
Have you worked as a Migratory/Seasonal Agricultural Worker within the last 24 months?		
Do you live in public housing or housing where you receive rental assistance?		
Are you homeless, at risk or homelessness, or your primary residence a shelter, transitional housing, or other temporary living setting?		
Are you best served in a language other than English, including sign language?		
Vaccine Administration Screening Questions	**Yes**	**No**
Are you significantly ill today? (Defer vaccine)		
Have you tested positive for COVID-19 OR had a known high-risk exposure to COVID-19 in the past **10 days** and been advised to remain at home? (Defer vaccine until quarantine lifted)		
Have you received convalescent plasma or monoclonal antibody treatment for COVID-19 in the past 90 days? (Defer vaccine for 90 days)		
Have you received ANY vaccine(s) in the past 14 days? (Defer vaccine for 14 days past last vaccine)		
Have you ever had an ANAPHYLACTIC reaction to **any injection** in the past? (Consult Clinician/Consider Delaying Vaccine)		
Have you ever had a SEVERE ALLERGIC REACTION in the past or received dermal fillers? (Observe for 30 min)		
Are you immunocompromised or receiving immunosuppressant therapy? (You may still receive the vaccine, but may have a diminished immune response to this vaccine. Consider consulting your treating Clinician)		
Do you have a bleeding disorder or are you taking blood thinners? (May still receive vaccine)		
Are you pregnant, might be pregnant, or breastfeeding? (May still receive vaccine)		
Do you have any questions about the COVID-19 vaccine that you want answered today?		
Have you ever received a dose of COVID-19 vaccine?		
If yes, which vaccine? Pfizer ☐ Moderna ☐ Janssen ☐ Date: _____		

I have received the **Fact Sheet for Recipients and Caregivers**, have had the opportunity to ask questions regarding the vaccine being administered, and these questions were answered to my satisfaction. I understand the benefits and risks of the vaccine and hereby authorize administration of the vaccine.

Health Information: I understand that my health information may be shared across the Terry Reilly dental, medical and behavioral health divisions.

Assignment of Benefits: I authorize direct payment of medical benefits to Terry Reilly Health Services.

Release of Information: I authorize the release of any medical information necessary in order to obtain payment from insurance company, Medicare, and any other third-party payors.

Signature of Patient or Legal Guardian X_____Date _____

**** Office Use Only ****

Site: R ____ L ____ Deltoid Dose 1: ___ Dose 2: ___ Vaccine Card Provided ☐

☐ **Moderna COVID-19 Vaccine** (over 18) 0.5ml
☐ **Pfizer-BioNTech COVID-19 Vaccine** (over 16) 0.3ml
☐ **Janssen COVID-19 Vaccine** (Over 18) 0.5ml

Lot#: _____ Exp. Date: _____ (check QR Code on Moderna vaccine vial for exp. date)

Vaccine administered by: _____ Date: _____ Entered into EHR ☐

Notes: _____

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