ArnotHealth

COVID-19 Patient Information and Vaccination Sheet

Today's Date:_____ Primary Care Provider:_____

PATIENT INFORMATION

Last Name:	**First Name:**	**MI:**	**Date of Birth** (mm/dd/YYYY):	**Sex:** ◯ M ◯ F
Mailing Address:	**City:**		**State:**	**Zip:**
Home Phone #:	**Cell Phone #:**	**Work Phone #:**	**Email Address:**	

Preferred Contact Method (please select only one):
◯ Home Phone ◯ Mobile Phone ◯ Work Phone ◯ Email

Marital Status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed ◯ Other:

Office May Leave Message on Voicemail: ◯ Yes ◯ No

Emergency Contact Name:	**Phone #:**	**Relationship:**

EMPLOYMENT INFORMATION

Employer Name:	**Occupation:**
Employer Address:	**Employer Phone:**

DEMOGRAPHIC INFORMATION

Race: ◯ American Indian/Alaskan Native ◯ Asian ◯ Black/African American ◯ Native Hawaiian/Other Pacific Islander ◯ White

Ethnicity: ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Decline

Language Preference: ◯ English ◯ Spanish ◯ Other

RESPONSIBLE PARTY INFORMATION

Person responsible for the bill:	**Address (if different):**	**Phone #:**

PRIMARY INSURANCE COMPANY

Insurance Company:	**Birthdate** (mm/dd/yyyy):	**Patient's Relationship to Subscriber:**
Subscriber Name:	**Policy ID #:**	◯ Self ◯ Spouse ◯ Child ◯ Other
	Group #:	

CONSENT

Emergency Use Authorization: The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not completed the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available under an EUA is based on the existence of a public health emergency and the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks.

Consent: I have been provided and have read, or had explained to me, the information sheet about the COVID-19 vaccination. I understand that if this vaccine requires two doses, two doses of this vaccine will need to be administered (given) in order for it to be effective. I have been given an opportunity to ask questions which were answered to my satisfaction (and ensured the person named above for whom I am authorized to provide surrogate consent was also given a chance to ask questions). I understand the benefits and risks of the vaccination as described.

I request that the COVID-19 vaccination be given to me (or the person named above for whom I am authorized to make this request and provide surrogate consent). I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I authorize release of all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries

NYS Attestation: I understand that vaccine supply is currently limited and therefore, subject to strict prioritization in accordance with Centers for Disease Control and New York State Department of Health directives. With that understanding, I hereby certify under penalty of law that I am member of a priority group eligible for vaccination as determined by the NYS Department of Health.
False statements made herein are punishable as a class A misdemeanor pursuant to Section 210.45 of the Penal Law.

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO, Governor | HOWARD A. ZUCKER, M.D., J.D., Commissioner | LISA J. PINO, M.A., J.D., Executive Deputy Commissioner

Pfizer	1	2	Moderna	1	2
Astra-Zeneca	1	2	Janssen	1	

Print Name:_____ **Date of Birth:**_____

SCREENING QUESTIONS	Yes	No	Unknown
Are you feeling sick today?	◯	◯	
In the last 10 days, have you had a COVID-19 test or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	◯	◯	◯
Have you been treated with antibody therapy for COVID-19 in the past 90 days (3 months)? *If yes, when did you receive the last dose?*_____	◯	◯	◯
Have you ever had a serious or life-threatening allergic reaction, such as hives or difficulty breathing, to any vaccine or shot?	◯	◯	◯
Have you had any vaccines in the past 14 days (2 weeks) including flu shot+? *If yes, how long ago was your most recent vaccine?* _____	◯	◯	◯
Are you pregnant or considering becoming pregnant?	◯	◯	◯
Do you have cancer, leukemia, HIV/AIDS, a history of autoimmune disease or any other condition that weakens the immune system?	◯	◯	◯
Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, anticancer drugs, or have you had any radiation treatments?	◯	◯	◯

Recipient/Surrogate/Guardian Signature: _____ **Date:** _____

Relationship to the patient (if other than the recipient): _____Print Name: _____

For Immunizer/Pharmacist use ONLY:

VACCINE ADMINISTRATION INFORMATION

Which vaccine is the patient receiving today?

Vaccine Name	Administration		EUA Fact Sheet Date	Manufacturer & Lot Number
Pfizer/ BioNTech	❑ First Dose 0.3/30mcg	❑ Second Dose 0.3/30mcg		
Moderna	❑ First Dose 0.5/100mcg	❑ Second Dose 0.5/100mcg		
Astra-Zeneca	❑ First Dose	❑ Second Dose		
Janssen	❑ Single Dose			

- I have reviewed side effects with patient (and parent, guardian or surrogate, as applicable)
- I confirm that the patient (and their surrogate, if applicable) was given an opportunity to ask questions about the vaccination, and all the questions asked by them (and/or their surrogate) have been answered correctly and to the best of my ability.

Administration Site: ❑ Left Deltoid ❑ Right Deltoid

Vaccinator Printed Name: _____

Vaccinator Signature: _____ Date:_____