

Attest BioSciences

COVID-19 Vaccine Documentation/Consent Form

Patient Information (Please print legibly)

Last Name: _____ **First Name:** _____ **Middle name:** _____
Date of Birth: _____ **Biological Sex:** Female Male Unknown or Not Reported
Ethnicity: Non-Hispanic/Latino Hispanic/Latino (Central/South America, Mexico, Cuba, Puerto Rico, Other) Unknown/Not Reported
Race 1: White Black or African American Asian American Indian or Alaska Native
 Native Hawaiian or Other Pacific Islander Other Unknown or Not Reported
Race 2: White Black or African American Asian American Indian or Alaska Native
 Native Hawaiian or Other Pacific Islander Other Unknown or Not Reported
Race 3: White Black or African American Asian American Indian or Alaska Native
 Native Hawaiian or Other Pacific Islander Other Unknown or Not Reported
Residential Address: _____ **City:** _____
State: _____ **Zip:** _____ **County:** _____
Phone: _____ **Email:** _____

Screening Questionnaire

COVID-19 Screening Questions

1. In the past two weeks, have you tested positive for COVID-19 or are you currently being monitored for COVID-19? Yes No
2. In the past two weeks, have you had contact with anyone who tested positive for COVID-19? Yes No
3. Do you currently or have you in the past two weeks had a fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nausea, vomiting or diarrhea? Yes No

Immunization Screening Questions

1. Are you sick today (cold, fever, acute illness)? Yes No
2. Do you have any allergies to medications, food, a vaccine or latex? Yes No
3. Have you had a serious reaction to a vaccine in the past? Yes No
4. Have you ever had Guillain-Barre syndrome? Yes No
5. Are you pregnant or is there a chance you could become pregnant in the next month? Yes No
6. Are you currently breastfeeding? Yes No
7. Do you have a blood-clotting disorder or are currently taking blood thinners? Yes No
8. Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder? Yes No
9. Do you have cancer, leukemia, HIV/AIDS, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease or other condition that makes it hard for you to fight infections? Yes No
10. Do you have a weakened immune system or in the past 3 months, taken medications that weaken it such as cortisone, prednisone, other steroids, anti-cancer drugs or radiation treatments? Yes No

11. During the past year, have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug?

Yes No

12. In the past 4 weeks, have you received any vaccinations or a TB skin test?

Yes No

13. Do you have a disability?

Yes No

For my booster dose I choose: Moderna Pfizer J&J

I have been offered a copy of the COVID-19 Emergency Use Authorization (EUA). I have read, had explained to me, and understand the information in the EUA. I ask that the vaccine be administered to me. I consent to inclusion of this immunization data in the State of Ohio Immunization Information System (Impact SIIIS) for myself.

Signature of Patient

Date

Printed Name of Patient

Date of Birth

If patient is a minor:

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian

For Office Use Only

Vaccine: COVID-19

Route: Intramuscular **Dose:** ____mL

Manufacturer: Moderna Pfizer J&J Other _____

Lot Number: _____

Site: Deltoid Left Right

Expiration Date: _____

Other _____

Administered By: _____

Date Given: _____

Signature and Title of Vaccine Administrator