Covid-19 Vaccine Form

office use:
Immprint ☐ billed ☐
medicare ☐ no ins ☐

Name:____

Date of Birth:____________________ M______ F______

Address____

City, State, Zip____________________________________

Phone____________________ SSN____________________

First Dose ☐ Second Dose ☐

Are you over age 65, or do you have Medicare? Yes No

If yes, we need your HEALTH insurance card. (red, white and blue card)

Are you under age 65? Yes No

If yes, we need your RX insurance card.

Have you received any other Covid-19 vaccine? Yes No

If yes, which one?
Pfizer_______ Moderna______Johnson & Johnson_______

Have you had any other vaccines in the last 14 days? Yes No

Have you ever tested positive for Covid? Yes No

If yes, did you receive an monoclonal antibodies infusion at the hospital as a treatment? When?

Are you allergic to any oral medications? Yes No

Have you had an allergic reaction to an injectable medication? (vaccines or other) Yes No

Have you had an <u>anaphylactic</u> reaction (swelling in the mouth or throat that inhibits breathing), or been told by a doctor to carry an EpiPen? Yes No

I have read the Emergency Use Authorization Fact sheet for the Covid-19 vaccine and I understand the risks and benefits associated with vaccination. I give permission for the above named patient to receive the vaccine indicated. I authorize billing insurance for an administration fee for the vaccine provided.
Signature of person to receive the vaccine or authorized representative or legal guardian:

X__________________________________ Date:____________

☐ First Dose
☐ Second Dose