Lower Umpqua Hospital District

2020-2021 SARS-CoV-2 (COVID-19) Immunization
Authorization to Release Information and Acknowledgment

Please print legibly:

Last name:	Date of Birth: Gender: M F
First name:	Telephone #:
Street Address:	City, State, Zip Code:

SARS-CoV-2 (COVID-19) ADMINISTRATION RECORD

Please answer the following questions:

• Are you age 18 or older?	❑ Yes	❑ No
• Are you ill or with a fever (temperature of 100.0 F or greater) today?	❑ Yes	❑ No
• Have you ever received a dose of COVID-19 vaccine? If yes which brand/date? _____	❑ Yes	❑ No
• Have you had any previous severe allergic reaction to any of the following: (e.g., aphylaxis) that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) ○ Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures ○ Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids. ○ A previous dose of COVID-19 vaccine or other vaccine or other injectable therapy ○ A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction. ○any other medical treatment or environmental allergy?	❑ Yes	❑ No
• Have you received any other vaccination in the past 14 days?	❑ Yes	❑ No
• Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	❑ Yes	❑ No
• Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	❑ Yes	❑ No
• Do you have a bleeding disorder or are you taking a blood thinner?	❑ Yes	❑ No
• Are you currently pregnant or breastfeeding?	❑ Yes	❑ No
• Do you have dermal fillers?	❑ Yes	❑ No

I appreciate that it is not possible to consider every possible complication to vaccination.
I have had an opportunity to ask questions about this vaccination.
I believe I understand this information, and my questions have been answered to my satisfaction.
I understand the benefits and risks of the COVID-19 vaccine and request the vaccine be given to me.
I CONSENT to informing LUH and the State Immunization Registry that I have received the COVID-19 vaccine.

Signature of Person Receiving the Vaccine:	**Date:**

Administrator Use Only

	❑ Dose 1 ❑ Dose 2	**Site of Injection (IM):** ❑ **R Deltoid** ❑ **L Deltoid**

Vaccine Mfr., Lot #, & Exp.	❑ Pfizer	□ Johnson & Johnson
	❑ Moderna US, Inc	❑ Astra Zeneca

Administered by: **Signature:**	**Date/Time:**