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| **Lower Umpqua Hospital District 2020-2021 SARS-CoV-2 (COVID-19) Immunization Authorization to Release Information and Acknowledgment** |  |

***Please print legibly:***

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| --- | --- |
| Last name: | Date of Birth:Gender: M F |
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| First name: | Telephone #: |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Street Address: | City, State, Zip Code: |
| **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 |
| * Do you have any chronic health conditions such as heart disease, lung disease, liver disease, diabetes? If yes, explain:
 |  |  |
| * Have you ever had a seizure, a brain disorder, Guillain-Barre syndrome or other nervous system problem? If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |  |  |
| * 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 passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19? If yes, what date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |  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 and understand the most current information sheets on Moderna and Pfizer vaccinations are available to me on site.****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 my insurance carrier, LUHD 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 **** Dose 3  | **Site of Injection (IM):**  | ** R Deltoid  L Deltoid** |
| **Vaccine Mfr., Lot #, & Exp. Date** | **** Pfizer | **** Johnson & Johnson |
| **** Moderna US, Inc  |
| **Administered by:** **Signature:** | **Date/Time:** |