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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 #: | | |
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| 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 |
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| **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:** | | | | | | | | | | | | | |